R.N.

JULY - 1952

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COVER CREDITS: Photographer: Walter Herstatt; cap and pin: University of Cincinnati, College of Nursing and Health, Cincinnati, Ohio.

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let's meet R.N. authors

Anne Falkenstein Jordheim is a graduate of the Cochran School of Nursing, St. John's Riverside Hospital, Yonkers, N.Y. Possessed of a B.S. and M.S. in Health Education from Teachers College, Columbia University, she has held staff, supervisory and teaching positions in New York, Philadelphia, and Chicago. Married to a Norwegian, she's now living in her husband's country.

As part of our series of articles on "Know Your Community Resources" we present an article on chiropody. Author **Raymond K. Locke,** D.S.C., F.A.S.C.P., attended Indiana University and the Ohio College of Chiropody. Current chairman of the Medical Relations Committee of the National Association of Chiropodists and the Qualifying Board of the American Society of Chiropodical Roentgenology, Dr. Locke, a practicing chiropodist, is also a lecturer and a frequent speaker to organizations in America and Canada.

After retirement—what? was the big question when **Emily C. Jessup** left her government job. Travel and writing were her answer. Her first trip was a five-month popular priced tour of Europe; next she flew to South America. She found courtesy and hospitality everywhere, came to consider herself an unofficial ambassador of goodwill. Back home now, she's busy writing.

Our space is too limited to list all the achievements of **Herman Goodman, M.D.,** author of several hundred articles and about a dozen books. Society is indebted to him too for his work on using ultraviolet light in criminal investigation and tattoo identification of newborn infants. Despite an active practice in dermatology and cosmetology, Dr. Goodman finds time to study medical history and judo, thus disproving the theory that doctors' hobbies consist solely of delving further into disease or playing poor golf.

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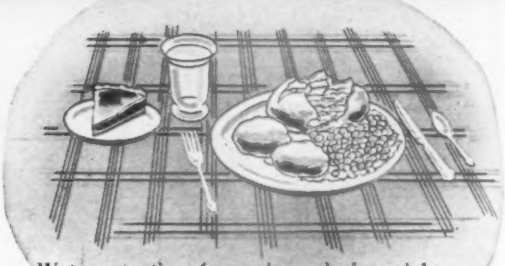

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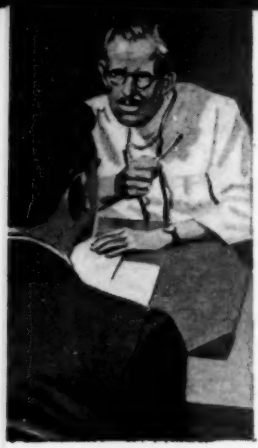

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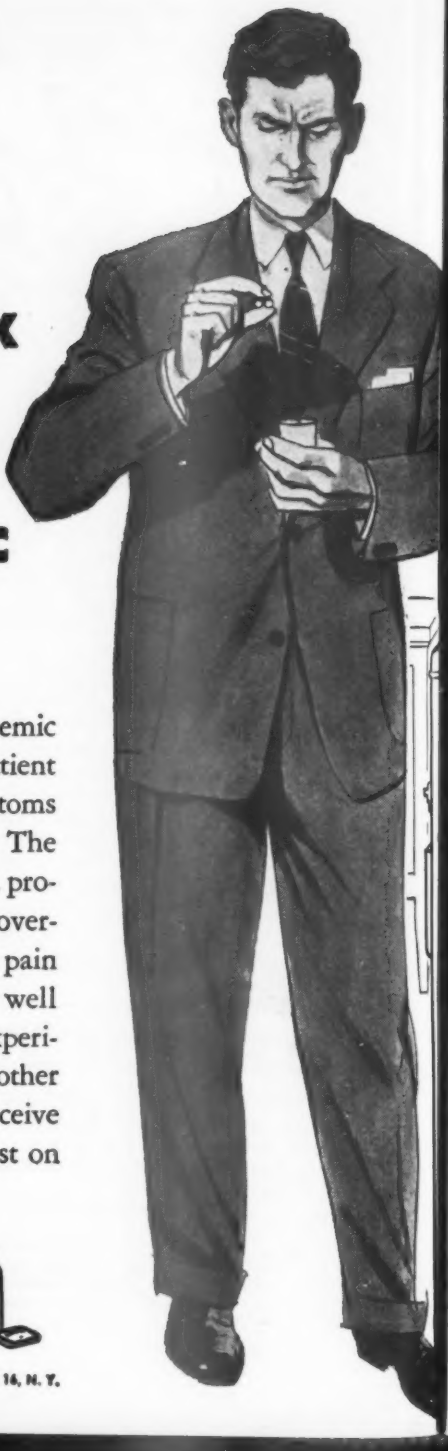

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DEBITS & CREDITS

HOW TO DO IT

Dear Editor:

I have 10 suggestions about keeping mentally and physically alert which may help the writer of the letter "When Is Too Old?" in the January **R.N.**, and all over-forty nurses who are looking for a new position:

1. Take a position in some hospital on general duty for a few months and learn about the new drugs and treatments and work side by side with the younger nurses.

2. Buy and read the book *You Are as Young as You Act* by Margery Wilson.

3. Read the magazines *Life* and *Time* regularly.

4. Have your hair restyled and set regularly.

5. Listen to the Hit Parade and learn the new songs.

6. Keep your figure trim and neat and buy some new clothes.

7. Treat yourself to nice soap and perfume and surround yourself with as many pretty things as you can afford.

8. Have a real hobby—gardening, dressing dolls, etc.—that you enjoy.

9. It is a foregone conclusion that all nurses read their professional nursing magazines.

10. Read the Help Wanted ads every day in some good newspaper—an especially good way to find an industrial nursing position.

(Mrs.) Margaret L. Walker, R.N.
Princess Anne, Md.

I.V. OR NOT TO I.V.

Dear Editor:

Nurses should not give I.V. medications and solutions. The responsibility for them should be that of the physician involved, and he should do it properly. Over the years, too many treatments that the doctors should attend to themselves have been passed on to nurses.

(Mrs.) Mary K. Gilleo, R.N.
Newburgh, N.Y.

* * *

I believe that a nurse should be allowed to administer I.V. injections but think that the nurses who are allowed to do so should have a course in the technique of administration. I know as a student nurse I was never taught to give any I.V. injections. My suggestion would be to have the anesthetists in a hospital teach the R.N.s this procedure.

R.N., Boston, Mass.

* * *

I favor the rule of the doctor doing I.V.s 100 per cent. It has never been a nursing procedure. Any medication of that type should be the doctor's responsibility. If the hospi-

tals want nurses to do these procedures, however, they should employ a nurse who has been specially trained in the surgical and medical field, and require her to do only medications. I'm sure patients would prefer this.

R.N., SAN DIEGO, CALIF.

° ° °

I have always been of the opinion that nurses should be trained properly to administer I.V.s and legally permitted to do so. Also, in training, we should be taught the correct way to take blood pressures. Why should not R.N.s be competent instead of being held back by idiotic ideas such as the belief that long-sleeved uniforms shouldn't be replaced by short-sleeved ones, or the old saw that the 40-hour-week should be enjoyed by everyone but the R.N. Or the theory that we should earn about ten cents a month and be grateful for same. We give I.V.s and do blood pressures on my job, and the various states, upon granting the R.N., should make it perfectly legal for us to do these procedures.

MARY E. WAGNER, R.N.
VAN NUYS, CALIF.

° ° °

Intravenous therapy is becoming so common that it has of necessity become a topic we can no longer ignore. While at our hospital nurses have been giving I.V.s for some time due to the lack of interns, an increase of bed patients and an influx of new doctors made the situation so acute that our superintendent immediately took steps to protect our nurses as best she could. She approached the doctors upon the sub-

IODEX helps to restore the normal acidity of the skin (3.5 to 4.5 in most areas) . . . relieves pain and tenderness and promotes healing . . . effective in relieving itching so that scratching with its provocation of secondary infection is reduced . . . bland, soothing and non-irritating

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ject of the legality of the nurse performing a procedure which, strictly speaking, is still within the realm of medicine. The doctors realized the seriousness of the situation and agreed in a written statement to assume all responsibility for the nurse to administer intravenous fluids upon completion of a course in intravenous therapy given by a staff doctor. This proposal was brought to a vote at a staff meeting, and passed unanimously. Four staff doctors volunteered to be instructors, and our superintendent quickly found a place, time and equipment for their classes. Graduate registered staff nurses were given the first opportunity to apply for the classes, and as of this date every nurse on our staff has taken this educational in-service program. Private duty nurses also applied, and over three-fourths have completed the course. Of course, it takes more than one easy lesson to get into the vein the first time, therefore additional practice periods were made available. We feel that we have taken one step in the right direction. It is up to the ANA to push the American Medical Association to delegate this duty to the nurse legally, or protect the nurse in some form or other. We realize the doctor can delegate his authority, but not his responsibility.

EDNA WHITE, R.N.
SANTE FE, N.M.

OPINIONS, PLEASE

Dear Editor:

I am eager to know what other R.N.'s think of having O.R. technicians—who are not nurses but lay

people—scrub on cases in operating rooms. We have some of these technicians—former aides, medical corpsmen, orderlies, etc. who have taken a course in O.R. technique—and I do not feel that their use is any way to solve the nursing shortage. At best, these technicians have only a smattering of microbiology, anatomy and other needed subjects, and they are definitely not acutely conscious of the need for sterility, and yet they perform the same duties as a scrub nurse who has completed three years of training plus postgraduate work in her specialty. Standards in nursing? Perhaps my ideals are too high, but conditions like this make me wonder if nursing is really a true profession.

R.N., SPRINGFIELD, MASS.

[*If crystal gazing is permissible, we predict that in the not-too-distant future, O.R. experience will be omitted from the R.N.'s basic preparation, that is, if nurse educators continue to follow their present line of thinking. In this event, O.R. technicians will be the only recourse.*—THE EDITORS]

FOR ONE WORD

Dear Editor:

Not being a parent myself, I've hesitated for some time about expressing myself as freely as I would like to on a matter of considerable dismay to nurses. Why in the world don't parents get together and agree on uniform terms for their children to use when they have to go to the bathroom? If they feel such terms as bowel movement and urinate are too offensive, all well and good. I'm not telling them what to teach the children, all I'm asking is that they teach them some term which makes sense. Seems to me some of the tongue twisters children use are far more difficult to remember or pronounce than the proper terms. When my pediatric patients start fussing and speaking a gibberish I can't understand, 24 years of experience have taught me to run for a bedpan or a urinal. I suppose things like this help keep nursing from becoming too routine, but they also make it difficult.

ZELLA GARRITY, R.N.
ST. PAUL, MINN.

SPLIT RANKS

Dear Editor:

The sound common sense expressed in "Quantity or Quality?" in the April **R.N.** was most refreshing. It seems to me that there would be no shortage of nurses today if our three-year schools had not given way to degree courses which have resulted in a large group of people who have the training but won't do the work. (And if these college graduates do the same work as the three-year diploma school graduates, they must wonder if the additional training was necessary or worthwhile.) All the turmoil about higher education on an enforced basis has only split the ranks of the previous large group of well-trained and very capable women who had a definite job to do and did it beautifully.

R.N., NEW YORK, N.Y.

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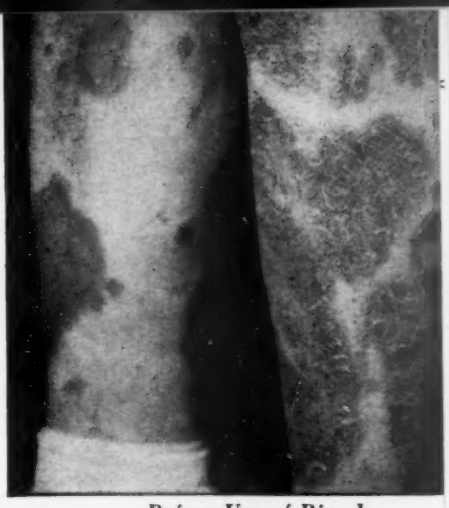

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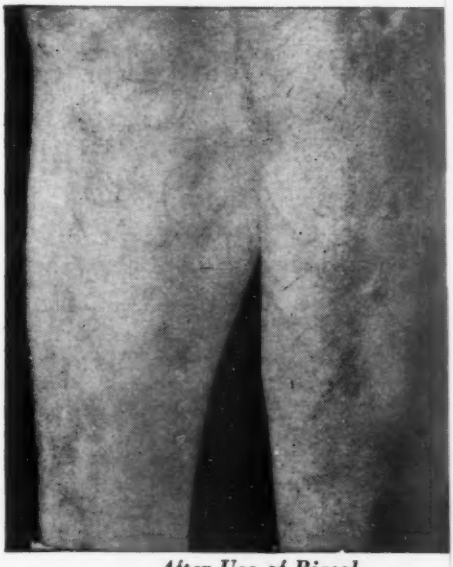

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1. Cronk, G. A.: Arch. Dermat. & Syph. (In press.)
2. Cronk, G. A., and Naumann, D. E.: J. Lab. & Clin. Med. 37:909, 1951. 3. Carrier, R. F., Krug, E. S., and Glenn, H. R.: Journal-Lancet 68:240, 1948.

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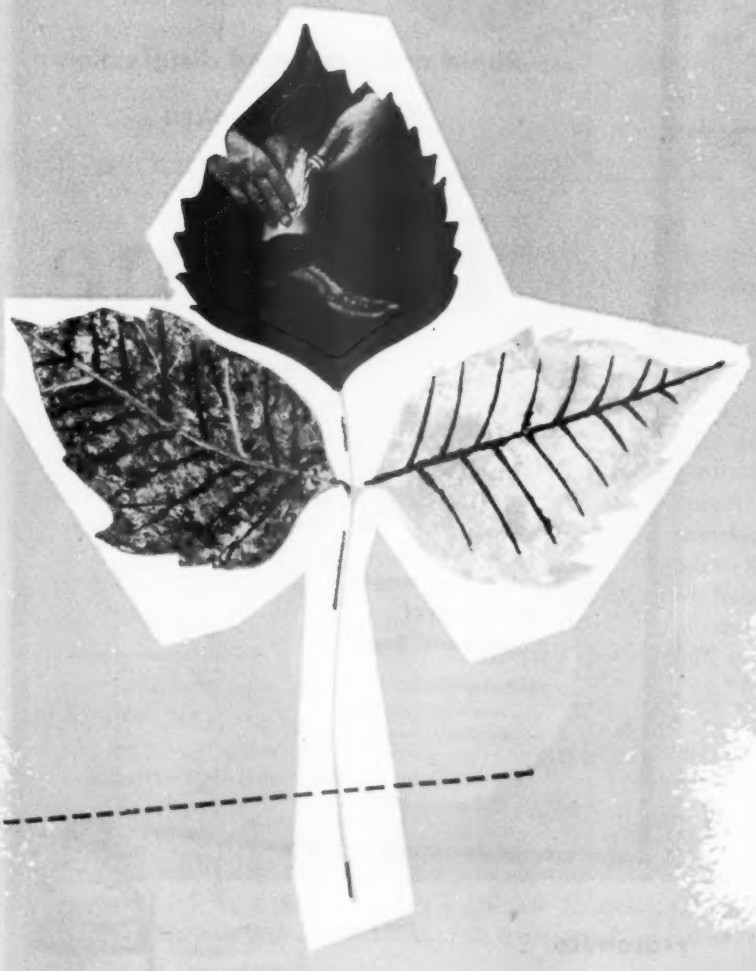

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SCIENCE SHORTS

Findings from studies by a group of scientists at the University of Western Ontario, London, Ont. show that the nerves and all tissues of the body show sex differences. Tissue cells of females contain two X chromosomes; tissue cells of males have only one X chromosome which is matched with a much smaller Y chromosome. It is thought that in those instances where the true sex of a child is difficult to determine, microscopic examination of skin cells may provide the answer.

*

Treatment with antibiotics and ACTH following severe burns is prescribed by Dr. Lester Eisenstodt, in the Journal of the Medical Society of New Jersey. *Dr. Eisenstodt recommends antibiotics to combat infection and ACTH to strengthen the patient against shock.*

*

The first color motion picture close-up of the inside of a living dog's heart has been made at the Montefiore Hospital in the Bronx. While the film was being taken, an artificial heart was used to keep the organ free of blood and the rest of the body supplied with blood.

*

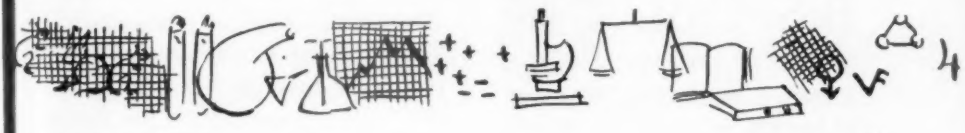
The death rate of the U.S. in 1951, about 9.7 in 1,000, was only one per cent above the all-time low mark set in the previous year, Dr. Louis I. Dublin, of the Metropolitan Life Insurance Company announced recently. Particularly significant was the drop in the mortality of tuberculosis to below 20 in 100,000 of population, a mark not anticipated for several years.

*

Decrying the tendency to ascribe all backaches to whatever particular cause happens to be the fad of the moment, Dr. Frank R. Ober, Boston orthopedic surgeon, states that back pain may result from any one of a great number of causes. At present, he finds that the diagnosis of "ruptured disc" is in vogue. Writing in the *JAMA*, Dr. Ober points out that back pain may result from injury, bad posture, congenital malformation, diseases of spinal bones and joints, malignant diseases, and diseases outside the spine. Real or fancied pain may arise from neuroses, chronic emotional disturbances, malingering, and various compensation problems.

*

Fourteen consecutive cerebrospinal meningitis patients were treated with terramycin by Drs. Archibald L. Hoyne and Emmanuel R. Riff of the Cook County Contagious Disease Hospital, Chicago. The doctors reported complete recovery in



every patient in an account published in the Journal of Pediatrics. *Two other types of meningitis were also treated successfully.*

*

Abrupt weaning of babies at three months may arouse fear and resentment and make pessimists of them in later life, reports psychiatrist Dr. Frieda Goldman-Eisler. Dr. Eisler makes the point, however, that pessimists are better money-makers even though they don't live as long as the optimists who undergo more leisurely weaning.

*

That undulant fever may lead to chronic disease of the aortic valve was pointed out by Dr. Thomas M. Peery, George Washington University School of Medicine, in a recent report to the American Association of Pathologists and Bacteriologists.

*

The fluoridation of public water supplies as a partial protection against tooth decay, says the *JADA*, is a "tremendous step forward in the profession's fight against dental disease." But there is a note of caution. "The artificial fluoridation of drinking water is not a cure-all. It will not protect children completely from dental decay."

*

A lead glass fabric gown designed for protection against x-ray radiation and beta radiation of atomic fission products is reported in the JAMA. *The gown, weighing 10½ pounds, is flexible, durable, washable and completely protects all exposed parts of the body, according to the article.*

ISABEL HAMPTON

PIONEERS

A Canadian gift to American nursing was Isabel Hampton.

After teaching in a small school in Ontario for 3 years, she came to New York and entered Bellevue. It was said of her that other student nurses could fold sheets more precisely and bathe patients more quickly, but none equalled her interest in their scientific and nursing surroundings. Miss Hampton completed her education at St. Paul's House in Rome, and then became Superintendent of Nurses at the Illinois Training School. She was a born leader, a teacher and a perfectionist, and soon completely revolutionized the teaching of nursing theory and practice, introducing such innovations as affiliation with Presbyterian Hospital in Chicago for instruction of pupil nurses in the care of certain types of disease. In 1889, she was asked to reorganize the Johns Hopkins School for Nurses. She became a guiding spirit in nursing education, working continuously for uniformity of educational standards and methods. Her initiative secured the establishment of a hospital economics department at Teachers College, Columbia University. Subsequently, she was Chairman of the International Council of Nurses. She, like so many others, fell under the influence of Florence Nightingale, and when she was married in England in 1894, she carried a bouquet of flowers which had been given to her by that patron saint of nursing. Isabel Hampton pioneered both the training of nurses as we know it today and the professional status of nursing as an integral part of the medical profession.

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R.N. SPEAKS: ON OUR O

■ IT'S A GOOD FIELD in which to grow old," writes an authority in a predominantly women's profession. This statement catches your eye. Is it the nursing profession that offers this security in old age?

You recall the experiences of nurses as they grow old in service; when aching feet, painful varicosities, and that accumulated tiredness catch up with them after thirty plus years of bedside nursing. What does the profession do for them or with them when age finally prevents older nurses from keeping up the required pace? Suddenly you are conscious of the prevailing custom that either drops them ruthlessly off into the void of unprotected unemployment, or, out of sympathy, tries to place them in easier but unsuitable positions.

Slowly you come to the realization that it can't be the nursing profession the author refers to. You are doubly convinced that it isn't when the point is made that the physiological process of growing older is recognized and anticipated in this field, therefore it is planned for. No woman should be deterred from entering for this reason, since supervisory or administrative positions with duties that do not require physical strain are ready for those who mature in the *service of social work*.

How does nursing compare with this profession? Many, too many, of the older nurses in our profession are just eking out a life of respectability bordering poverty. If they get sick or meet with an accident and *if* their plight comes to our attention, we give a benefit for them, or raffle off "baskets of good cheer" in their behalf.

The approach to the older nurse who must remain active for personal or family survival has generally been, "Can't we get some hospital to take her in?" or "Can't we get a registrar's job for her?" The casual position created neither utilizes the special gifts and experiences the older nurse has, nor does it give her the security and confidence a job should provide.

We have been forced into the position of categorizing the older nurse as a "problem." She wouldn't be a problem today if the profession had taken the initiative years ago and planned for her utiliza-

tion. Before World War II, only 5 per cent of the nurses actively engaged in nursing were over 55 years of age. In 1949, there were about 15 per cent over 50 active in nursing. In New York alone there were about 6,000 nurses 50 years and over who were still working, and 2,000 active over 60.

While our culture continues to put its emphasis on the maximum production for the greatest gain, our older workers in any field are either forced out of the field prematurely or are misused. While we approach the *needs* of the older workers rather than their *potentialities,* our solutions will remain unsatisfactory.

Fortunately, for many of us, but too late for some, a whole new philosophy is gradually being evolved in relation to the productive activity of older people. In time it should counteract the erroneous belief that as physical powers wane, productivity of the person wanes too. The emerging philosophy recognizes that *chronological age* has little adverse influence on the productivity of the individual *who grows all the time.* True, the older people in this group must modify and change the activities that demand physical exertion, but their experiences and wisdom, together with their limited physical resources, can be used in other forms of productive activities.

An eminent member of the medical profession, known for his keen observations, had this to say when the question of what to do with the older nurse was put to him: "There is no doubt that young doctors and nurses know many new techniques, and know them better than the older practitioners do, but the older ones know *people.* They've an understanding of both the disease under treatment, and the individual who has it."

The average nurse spends her adult years in useful activity. She becomes unusually well disciplined in one of the most "growing" experiences of life—that of thinking of others' needs before her own. She faces hard realities; she learns values; she knows how to adjust constantly to changing situations. As she reaches the climax of her professional life, she has qualities and skills that are [*Continued on page* 78]

Hauger & Dorf

■ JANE STEVENS gave a sigh of relief as the last few turns of the bandage were applied. At last the operation was finished! She snapped off her gloves, dropped her mask, and plunked down in the first chair she could find outside the operating room.

"Stevens, you look completely knocked out," said Dr. Wood on his way to the ward. "What's wrong?"

"If that operation had taken ten more minutes, I would have dropped at the table. My feet are killing me!"

"I'm awfully sorry to hear it," Dr. Wood said. "I've never heard you complain about your feet before. Have you done anything about them?"

"Well, frankly," Jane sighed, "I've kept putting it off but I just can't go on much longer without some relief. Dr. Ward, the internist, gave me a complete physical and couldn't find anything. He recommended that I have my feet examined soon by a chiropodist. Dr. Wood, what do you think about chiropodists? I've never been to one."

"Darn good idea!" said the doctor,

"Why don't you see one—one helped me, he might help you too."

Jane called my office the next morning and arranged for an appointment the following day. A few brief questions from me helped Jane to recite her complaints and past history. I then instructed her to remove her shoes and stockings and stand on a glass platform which was illuminated so that the plantar surface of her feet could be examined on weight bearing. I proceeded to examine Jane's general posture and the weight bearing structure of her feet and ankles. Jane watched me with interest as the examination neared completion. She noted that many of the instruments used, such as the percussion hammer, tuning fork, and oscillometer, were familiar to her. She commented on the thoroughness of the examination.

"It's amazing, Dr. Locke," Jane remarked when I had finished, "that your profession has received so little attention from nurses and the lay population."

I smiled: "Chiropody is an emerging profession, Miss Stevens, having gained recognition only quite recently. Ours has not been an easy fight. Too many people seem to take their feet for granted and pay very little attention to them. Medicine, itself, admits that it has fallen into the same way of thinking. The American Medical Association has deplored the apathy toward ailing feet manifested by the average general practitioner. Dr. Sumner Koch, Northwestern University Professor of Plastic Surgery, points out that of all medical school subjects, 'the most neglected is the foot.'

"An excellent article in a past issue of **R.N.** entitled 'Give Your Feet a Fair Deal,' by Lynne Svec, pointed out that 'forgotten' feet can cause backaches, poor posture, swollen ankles, pains in the thighs and legs, and a host of other ills, not to mention the more usual complaints such as corns, calluses, bunions, and ingrown nails."

"I'm glad you brought that up," said Miss Stevens. "I read the article and I remember that it refers to podiatrists. What is the difference between a podiatrist and a chiropodist? I'm mixed up."

"That is a confusing point to many people, Miss Stevens. But as I try to clarify it and the place of the profession of chiropody for you, let me talk to all **R.N.** readers."

All of the schools training foot specialists grant the degree Doctor of Surgical Chiropody (D.S.C.) except one which grants the degree Doctor of Podiatry (Pod. D.). A graduate D.S.C. calls himself a chiropodist and a Pod. D. calls himself a podiatrist. Since both have ex-

THE CHIROPODIST—his profession

by Raymond K. Locke, D.S.C.

actly the same training and qualifications, the two terms are synonymous. The term chiropodist (pronounced ki-rop'-o-dist) is much more widely used.

Too many people, unfortunately, are completely misinformed about chiropody and its scope of practice. They often have the impression that a chiropodist merely pares corns and calluses or treats toenails. Nothing could be further from the truth! The modern chiropodist is a foot specialist in every sense of the word. His course of study consists of at least one or two years of pre-chiropody (pre-medical) education, followed by four years in one of the six schools of Chiropody and Foot Surgery accredited by the National Association of Chiropodists. The curriculum of the chiropody student provides him with a well-rounded knowledge of the principles of medical practice with special emphasis on subjects relating to foot problems. Many of the states require an additional year of internship after graduation. Thus, the total study spans a period of five to seven years before the young chiropodist is permitted to take the required State Board Examination and begin practice. In several states, the examination includes a basic science examination in addition to the regular chiropody exam. These examinations are identical to those taken by doctors of medicine.

Some of the chiropody colleges are associated with universities so that, in many instances, leading members of the faculty teach at both the medical and chiropody schools. Each school has a large foot clinic attached to it where the students receive practical clinical instruction and experience. In addition, internships are served at many leading hospitals.

Because chiropody is a young and growing profession, 7,000 chiropodists serve the needs of 156 million Americans. Yet, according to surveys conducted among 500,000 persons by the National Association of Chiropodists, one out of every three Americans are in need of foot care. This ratio is undoubtedly higher in certain occupations that require prolonged standing. Even the armed services have failed to provide foot specialist care for the foot troubles of the soldiers, sailors and marines.

During a recent chiropody convention held at Des Moines, Iowa, the eminent surgeon Charles W. Mayo stated, "I am convinced that doctors of medicine, myself included, have paid too little attention to the feet in their relationship to the condition of a patient, and have made too cursory an examination of the feet, considering their importance to people with the 'beating they take' and their potentiality as a source of comfort or discomfort. The doctor of medicine should be capable of recognizing foot ailments, and when care and treatment of such conditions are necessary, should refer the patient to those accredited and skilled in that specialty when such consultation is available."

The chiropodist renders an especially valuable service to the diabetic and [*Continued on page* 72]

CAN DID COMMENTS——

Our Untapped Resources

■ LOUIS PASTEUR discovered that certain diseases were preventable and thereby let loose a chain of events never before equalled in medical history. In the subsequent health "revolution," a great army of new workers came into action, and the entire scene was radically changed as major germ-produced diseases were brought under control. But a whole new set of urgent problems is at hand at the second half of this century mark. Above all is the new attitude toward health. Our growing population wants more complete health coverage, not only for all the people from the cradle to the grave, but also in every phase of the health cycle—prevention, health promotion, acute illness, convalescence and finally rehabilitation.

Nursing, moved by these events, has shot up like an adolescent child. Today, in its new position as a major force in the health army, it is on the hottest spot it has ever known. Everything we learn and do must be geared to the rapid strides of science and the health hungers of our people. It is small wonder then that there is conflict of ideas on which practices of the past era must be modified or replaced by those introduced in the new.

The profession generally accepts the idea of broader, stronger basic education. It accepts the idea too of a more economical and effective use of professional nursing service through the use of auxiliary aides. No one who knows nurses can doubt the willingness and eagerness of the majority to adjust practices to what is best for the patients, even though this might cost individuals a price in place, prestige, and opportunity for advancement.

It is my opinion, however, that there is a growing resistance to some of the new methods instituted by the policymakers who are setting the stage for a new pattern in the care of the sick. I do believe that more problems are being created than are being solved. Certainly we cannot blame all of the bad nursing care some patients get on shortages of personnel. Anywhere from six to twelve people may now serve him directly in place of the one or two of the past, and mighty few patients seem to feel the change is for the better. A veteran nurse educator, after listening to a "team captain" sum up the points of a demonstration in the care of the patient by five types of personnel, commented acidly, "I wonder how in the world the

by Janet M. Geister, R.N.

patient can survive—or the student nurse observe."

True, we are in an experimental period, trying out various methods. This fact should be kept in mind by those who state arbitrarily what the future of nursing will be, as well as by the rest of us. There is resentment over the encroachment on the time-honored place of the nurse beside the patient. There is a lot of difference between what the harried administrator has to get done today and setting the standards of nursing practice for tomorrow. We just don't know today where the lines will be drawn between the rounded service of the past and the divided service of the future. And while we are learning, the work of the professional nurse at the bedside should be respected as much as apparently is that of the auxiliary worker.

It appears to me that two things are urgently in order: the greater participation of experienced nurses in the discussions that lead to plans and decisions, and a more direct means than is now available for this participation. The weakness of the present lies in what we haven't done. We have not begun to tap the *idea* resources within the profession to get the soundest answers to our huge problems. The custodians of nursing aren't all on boards, committees, and commissions; they include many nurses in many places who think, and who yearn over nursing and good patient care. The article, "Reverence for Life" [R.N., May, 1952] brought more appreciative comment than any [*Continued on page* 57]

PACKING TIPS for VACATION TRIPS

■ FROM OUR OWN traveling experience we have discovered that the joys of a vacation trip can be heightened by minimizing little irritations that come from packing the wrong things, or rather from not selecting rightly for expected needs. Destination, length of stay, the weather, and individual taste determine what shall be packed in traveling bags, but with a few basic requirements in mind, one can proceed more certainly.

Luggage: Two bags, well packed, will hold enough clothes for a four months' trip. One should be a large suitcase, of light construction, the 16 x 29 inch size; the other, a soft bag weighing 10 to 12 lbs., that when packed can be handled by yourself, if that is necessary. In the soft bag, you can pack night clothes and toilet articles. For just an overnight stay in some city, you need not disturb the suitcase. It could even be left in a locker at the airport or station. Much luggage carries with it much confusion at the station or airport, at hotels, and at customs. It is a relief to be able to say to the porter, "Those two, they're the only bags I have." Incidentally, less baggage means less tipping, which mounts up astoundingly as you travel onward.

It is a good idea to begin a week ahead to put little things into your bags—just so you'll remember them.

Space will be at a premium, therefore, when you begin to pack, hold up each item, look at it carefully and think, "Is this absolutely necessary?" In most instances you will conclude that it isn't. Yet with wise choosing, you will be able to pull out of your two bags articles right for any occasion that may arise.

Those Accessories: Take extra hats but choose those that will pack flat among your clothes. It will be a temptation to take that newest creation, but if you yield, you won't recognize the mess when you open your suitcase at the first stop.

A purse with handles is the one most easily carried. It should have zipper compartments to hold traveler's checks and identification papers. Count out the slippery envelope variety.

Your Funds: Traveler's checks made out in small denominations make for convenience. You are carrying less cash that way, and outside this country you won't be left with foreign currency on your hands which means only so many wooden nickels to you after leaving. A fair-sized amount might be disposed of in the bordering country, but usually at a big discount.

Wearing Apparel: Perhaps you are traveling where you will need both warm and light clothes. Then take a suit and a wool dress, a medium-weight coat and a sweater in addition to summer dresses. From experience we advise you to travel with one coat; the space coats take up in a bag just isn't worth it.

One should pack in anticipation of the unexpected. In going to Hawaii, for instance, one wouldn't expect to need warm clothing, but on the air excursion trip around the small islands the air is quite cool. An airplane is always chilly and a sweater is usually more comfortable and easier to wear than a coat.

Include a thin plastic raincoat and rain shoes that can be carried in your purse on a day's excursion. With this protection, that bothersome appendage, an umbrella, is unnecessary.

Sundry Tips: In packing, utilize every little space. Pack bottles in your shoes, snap a rubber band around them, and shove into a shoe bag or paper sack. A supply of rubber bands and a length of twine come in handy, too. Go easy on taking shoes; they are bulky and hard to pack. Heelless shoes take up less room.

One of my pet devices for packing is large, plastic envelopes. You can buy plastic cloth and make them yourself. Stitch them as you would cloth and hold the seams together with paper clips. In this way, you can segregate and protect stockings, underwear and toilet articles. With plastic, you have no problem in packing a wet washcloth or undies that were washed but didn't quite dry before travel time. Take your cleansing tissues out of their cardboard box and slip into one of these envelopes that can be packed more easily than the resisting cardboard box. Always carry your cosmetics in metal tubes and [*Continued on page* 64]

by Emily C. Jessup

LEAVES

■ THAT MYTHICAL PERSONAGE, Mother Nature, isn't quite so benevolent as many would like to believe. For verification, just ask the veterans of ivy poisoning who have been stroked by some of her glossy green leaves in the fields or woods.

Of all cases of dermatoses caused by plants, ivy poisoning is by far the most common. Although it occurs frequently among farmers, gardeners, horticulturists and other land workers, it also affects numerous vacationers and child campers who pick the plants or accidentally brush past them. Studies conducted by the USPHS have indicated that about 350,000 cases of ivy poisoning occur every year in the U.S., accounting for a loss of approximately 600,000 work days. In the USPHS survey, 71.9 per cent of the ivy victims needed medical attention, and 17.7 per cent were bed patients for about three days. On the average, the symptoms persisted for ten days.

When one considers that ivy poisoning may spoil a vacation or keep one from work for several days, it would seem wise for all country-goers, both children and adults, to become acquainted with the appearance of these troublesome plants.

For those who are not botanically-minded, the best rule to follow in giving the plants a wide berth is that expressed in the old rhyme: "Leaves three—let it be." However, one should remember that poison ivy often creeps up on you unawares since it may be hidden from view by other foliage. It may appear as a vine clinging to trees or poles or climbing over fences and walls, it may trail along the ground, or it may grow in the form of erect shrubbery. In summer the leaves of poison ivy, which is dignified by the name of Rhus toxicodendron radicans, are green and glossy; in the spring and fall they are russet-colored. The white waxy berries of the plant resemble mistletoe berries.

Another plant, sometimes called poison sumach, poison dogwood or

poison elder, contains the same toxic principle as poison ivy and is just as irritating to the skin. This plant grows erect in large shrubs or small gray-barked trees and may be found in swamps and boggy soils along the Atlantic coast. Its leaves are arranged in pairs directly opposite each other with a single leaf at the end of the stem. In contrast to the red berries of the non-poisonous sumach, the berries of poison sumach are waxy and cream-colored and hang in drooping clusters. The third member of this poisonous triad is poison oak whose leaves, similar to those of the oak tree, grow in groups of three. Like poison ivy it may appear as a climbing vine or as a bush.

The irritating properties of all three of these plants which belong to the genus Rhus have been traced to urushiol, a non-volatile oil present in the resin of the leaves, flowers, fruit, stem, bark and roots. The sap is said to be particularly virulent during the budding season of spring and early summer.

Usually Rhus dermatitis (ivy, oak and sumach poisoning) is caused by direct contact with some part of the plant; the irritant is then spread from the hands to the face and other parts of the body. But, toxin may also be carried by contaminated objects such as garden tools, clothing and animals. It is said that the sap, which is not easily removed by washing, may retain its toxic property for several months. Exposure to smoke from burning of poison ivy may also cause ivy poisoning in susceptible persons.

Although some claim to be immune, it is doubtful whether one should place complete confidence in his immunity. Often an immune person may be exposed to poison ivy for years without being affected by it; then for some unaccountable reason he may develop sensitivity. Dermatitis is more likely to appear when the skin is wet or damp with perspiration. It has been estimated that about 60 per cent of the population show some sensitivity. Since one never knows the status of his immunity it is best to keep a respectable distance from the plants or, if contact occurs, to try to neutralize the toxin.

Fortunately, there are ways of removing the irritating substance before it has a chance to penetrate the skin. If you suspect that you have touched poison ivy, the best preventive of a full-blown dermatitis is several generous latherings of the exposed skin areas with yellow laundry soap, each sudsing followed by rinsing under running water. In this way the toxic oils are removed or rendered less irritating. Some recommend washing with a solution of trisodium phosphate. (Oakite Cleaning Powder—1 teaspoon to 1 quart

THREE -- LET IT BE

by Frances Lewis, R.N.

of water) before washing with soap, and the use of a solvent such as alcohol or benzene after the soap washing. Solutions of ferric chloride and potassium permanganate have also been used as skin protectives, but both have the disadvantage of staining the skin. In an effort to find some substance that would protect field workers from poison ivy, a group of USPHS doctors developed a protective vanishing cream containing non-irritating oxidizing agents like sodium perborate which liberate oxygen to neutralize the poisonous resin.

If the toxic substance of the Rhus plants is absorbed by the skin of susceptible persons, the first symptoms of burning and itching may become evident any time from a few hours to a week after exposure. These symptoms are soon followed by rash and swelling and the appearance of small or large vesicles. A liquid from these vesicles dries to form scabs or crusts. One who has gone through a siege of severe ivy poisoning can sympathize with its victims. The intolerable itching and oozing discomfort of this dermatitis makes it one of the most uncomfortable skin diseases there is. Fortunately, however, unless infection or further contamination complicate matters, the disease is self-limited—and definitely curable.

There are so many types of treatment for ivy poisoning that one cannot be dogmatic in stressing the value of any one. There are available any number of antipruritic ointments, lotions, powders and creams, local anesthetic ointments, antihistaminics and other remedies which have proved efficacious in certain stages of the affliction. During the early or incipient stage it is wise to avoid the use of creams or ointments that might spread the contaminant to other areas. A Federal Security Agency pamphlet states that when there are only a few blisters on the extremities, a home treatment of a 10 per cent alcoholic solution of tannic acid may be applied, but in severe cases of poisoning and when the face or genitalia are involved, the doctor should always be called. Agents used in the prevention or treatment of ivy poisoning and described in *Drug Digest*, page 36, are potassium permanganate, tannic acid, Rhus extracts and calamine. Again, it should be emphasized that many other agents are used in lieu of or in addition to these four. Recently there has been much publicity over a new ivy poisoning ointment containing the metal, zirconium. Favorable results on its protective and therapeutic action have been reported in studies at Syracuse University.

One of the old wives' tales about poison ivy is the story that you can prevent poisoning by eating parts of the plant. It has been shown, however, that ingestion of the toxic substance may lead to serious inflammation of the mouth, pharynx or rectum. Also, ingestion may cause vomiting, drowsiness, stupor, dilated pupils, convulsive movements, delirium and fever.

The question of whether ivy pois-

oning can be prevented by injections of Rhus extracts is disputable. According to the *N.N.R.*, "Evidence indicates that subcutaneous injection of several doses of extract of increasing strength renders many susceptible people immune to casual contact. Although this evidence is not entirely satisfactory, at present this is the method of choice." The *N.N.R.* also says that extracts of poison ivy, oak or sumach will be considered by the Council for prophylaxis but not for treatment, and that "Extracts of poison ivy, poison oak or poison sumach may be used interchangeably for the prophylaxis of the dermatitis caused by contact with any of these plants."[1]

It is obvious that if one wants to avoid the discomfort of ivy poisoning, all possible ways of eliminating contact with the offending plants should be investigated. When poison ivy grows abundantly near the home it should be eradicated.[2] If it is utterly impossible to escape contact, a campaign should be waged against it, using all the defensive weapons at one's command. When warnings are heeded and protective measures are followed, there is no good reason why nature should gain the upper hand.

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[1]*New and Nonofficial Remedies* 1951, J. B. Lippincott Co., Philadelphia, p. 3-4.

[2]Methods of plant eradication are described in Farmer's Bulletin No. 1972, prepared by the U.S. Department of Agriculture. This 10-cent booklet may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C.

Probie

"You're impeding the progress of science."

DRUG DIGEST

Potassium Permanganate U.S.P.

(Oxidizing Agent)

PRODUCT NAMES: Distributed under its official name.

PHARMACOLOGY: Solutions of potassium permanganate, a strong oxidizing agent, are characterized as irritant, astringent and deodorant. Although organisms may show a varying susceptibility to the compound, it has been found that bacteria may be inhibited or destroyed by dilute solutions. Solutions serve as astringent and antiseptic fluids for the irrigation of body cavities, as cleansing agents for wounds and mucous membranes, and as oxidizing antidotes in alkaloid poisoning. A strong solution of potassium permanganate applied to skin areas exposed to poison ivy may prevent dermatitis because of its oxidizing action on the poison ivy toxin, urushiol. Solutions are also employed in the treatment of poison ivy and other dermatoses.

DOSAGE: A 1:1,000 to 1:5,000 dilution is used for the irrigation of the vagina and bladder. A 1:5,000 to 1:10,000 solution may be used as a gastric lavage in internal poisonings. In poison ivy therapy a 1:9,000—1:12,000 solution used as a compress, wash or soak is indicated. Potassium permanganate is no longer effective when it turns brown.

UNTOWARD ACTIONS: Concentrated solutions of potassium permanganate are irritating to the skin, and large internal doses may cause gastro-enteritis. One of the main drawbacks to the use of this compound is its staining of the skin, and clothing and bed linen. Stains, however, may be removed with dilute oxalic or sulfurous acid.

Calamine U.S.P.

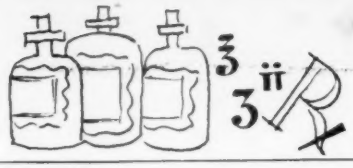
(Protective)

PRODUCT NAMES: Antipruritic agents containing calamine include: Caladryl, Calamatum, Calamer, Calamoin, Caligesic Ointment, Calizinc, Calmaloid, Comfortine, Di-Paralene Calamine Cream, CZO with Benzocaine, Enzo-Cal.

PHARMACOLOGY: Calamine, a pink, odorless and tasteless powder, has protective properties similar to those of zinc oxide when applied locally in the treatment of skin afflictions, such as eczema, insect bites, minor abrasions, rashes, and ivy, oak and sumach poisoning. The addition of phenol to calamine preparations gives them an antipruritic, local anesthetic and antiseptic action. Other substances which may be combined with calamine are camphor, zinc oxide, benzocaine—a local anesthetic —and ammoniated mercury—an antiseptic ointment. Calamine lotion dries on the skin leaving a smooth protective covering of the substances dissolved in it.

DOSAGE: Calamine may be found in creams, lotions and ointments. The best known form is calamine lotion which is poured or dabbed on the affected areas as often as is desired. Calamine preparations are designed solely for local application.

UNTOWARD ACTIONS: Calamine is a non-irritating substance. No toxic effects have been reported from its use.



Tannic Acid U.S.P.

(Astringent)

PRODUCT NAMES: Ivy-Dry, Rhulitol, Rhulicream, Tannic Spray Gebauer's—tannic acid preparations used in ivy poisoning.

PHARMACOLOGY: Tannic acid is a tannin generally obtained from nutgalls, the outgrowths found on oak tree twigs. Tannins have been used to some therapeutic advantage in burns because of their property of forming eschars and checking secretions, and in diarrhea because of their protective action on mucous membranes. Tannic acid is employed in the treatment of ivy poisoning as a result of its ability to protect and heal the blistered and exuding skin areas.

DOSAGE: For treatment of small blisters caused by poison ivy, a 10 per cent alcoholic solution of tannic acid may be used. The tops of the blisters are rubbed off with a sterile gauze pad that has been dipped in the solution. Then the tannic acid is applied as a lotion every six hours until three or four applications have been made. Tannic acid preparations may also be applied as wet dressings or sprayed over the affected skin area.

UNTOWARD ACTIONS: Tannic acid should never be used near the eyes or genitalia because of its irritating effect. Special care must be taken when tannic acid is applied as a spray. Although tannic acid darkens the skin, this discoloration will disappear after treatment is discontinued.

Rhus Extracts

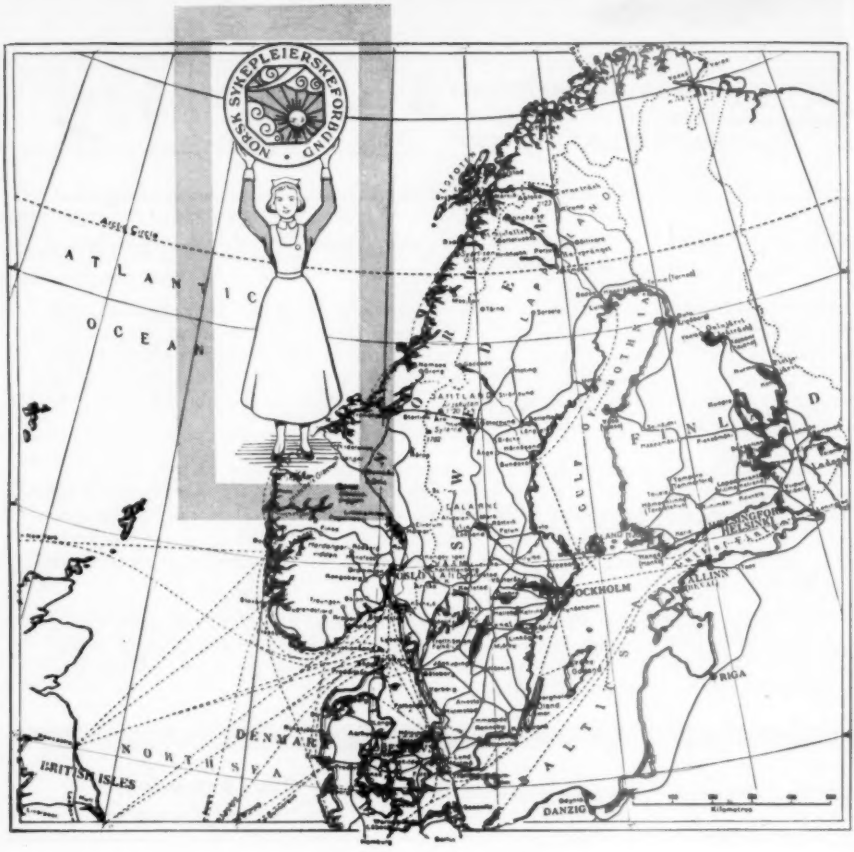
(Ivy Poisoning Preventives)

PRODUCT NAMES: Poison Ivy Extract, Poison Ivy Extract in Vegetable Oil, Rhus Tox Antigen, Poison Ivy Extract with Sterile Diluent, Ivoko, Poison Oak-Ivy Extract, Ivoko Poison Ivy-Poison Oak Extract with Sterile Diluent, Poison Ivy-Sumac Extract, Poison Oak Extract, Poison Oak Extract with Sterile Diluent, Rhus Venenata Antigen —all **N.N.R.**

PHARMACOLOGY: Extracts of poison ivy, oak, or sumach are standardized biologically by determining the weakest dilution that will cause patch test reactions in about half of a sample group of adults. Although studies have indicated that these extracts have preventive value, some authorities question their use in the treatment of Rhus dermatitis.

DOSAGE: Weekly injections by the subcutaneous route may be begun in January, February or March and continued throughout the summer. The initial dose of 0.02 cc. may be progressively doubled in succeeding doses unless a reaction occurs. Hyposensitization is usually required from year to year. Since traces of the extract on the skin following injection may cause contact dermatitis, the outer surface of the needle should be wiped with alcohol or acetone before injection.

UNTOWARD ACTIONS: Possible reactions to injection of the extracts include malaise, fever, nausea, vomiting, muscle pain, urticaria, angioneurotic edema, and local inflammation. In a few cases, toxic nephrosis may occur.



NURSING in NORWAY

■ ONE OF THE first nurses I met in Norway was the director of nursing in one of Oslo's foremost city hospitals. She spoke perfect English with what I suspected to be a real American accent. Over a cup of tea she asked me to tell her a little about my nurse's training, the work I had done in America, and my various graduate studies. As she listened, her eyes began to sparkle.

"Just a minute," she exclaimed, "you don't mean to say that you affiliated at Bloomingdale? What a coincidence! I worked there once, some twenty years ago. Do they still have those lovely flowers on Easter Sunday?"

A little later, when we discovered that we had studied at the same university and had many mutual acquaintances, I began to wonder at the smallness of the nursing world. As a visitor from abroad, I was struck at once by the international-mindedness of my Norwegian colleagues.

Not only have most of the older nurses in leading positions seen a bit of the world, but they speak several languages. The younger ones are definitely encouraged to travel outside of their own country to learn and study more. Just look around you. Haven't you met at least one Norwegian nurse who is either working or studying in America? Haven't you read about the Norwegian nurses who—all over the world—help with the BCG vaccinating campaign of the World Health Organization? And how about the Norwegian hospital in Korea which is doing such a fine job taking care of wounded United Nations soldiers? This nursing activity is amazing when we consider that Norway is a relatively small country with only 3,500,000 inhabitants, and only 27 *hospitals with schools of nursing!*

In many respects the basic nurse's training in Norway is very similar to our three-year course in America.

as seen by Anne Falkenstein Jordheim, R.N.

Not all of the hospitals have psychiatric affiliations but it is hoped that this type of training will be included eventually. Also, student nurses have very little delivery room experience, as well-prepared midwives are employed in all Norwegian maternity units, and work almost exclusively in delivery rooms. However, this is in the process of being changed. Actually, the Norwegian nursing curriculum differs chiefly from the American curriculum in its inclusion of classes on the Bible, on ethics and psychology based on Christian teachings. These subjects are generally taught by the hospital chaplain.

The system of higher education in Norway is quite different from that found in America. There are no university schools of nursing. And a graduate course in nursing could not be included in the university curriculum. However, the Norwegian Nurses Association (Norsk Sykepleierforbund or NSF) does maintain a postgraduate school for qualified nurses who can enroll for a one-year course in education, administration, public health nursing, or in related specialties such as x-ray technique, anesthesia, and medical technology. The school can accommodate 200 students a year, and the curriculum consists of 700 hours of theory and six weeks of practice. Every year the students take a two weeks' study tour in some other European country. Last year they visited England; this year they are planning to go to Holland. These trips are financed by the students themselves. There is also a State School of Public Health in Oslo where students can study for nine months under scholarships provided by the state.

Norway does have a few male nurses who have trained or are in training now in the large city hospitals. There are also Protestant deacons who, after they become nurses, go all over the world to work, per-

haps in the Norwegian Army or as assistants to missionaries or seamen's pastors.

The Norwegian Nurses Association has a membership of some 7,200 nurses who must have been graduated from a recognized school of nursing. Nurses from other lands whose credentials have been approved may also become members. The NSF is affiliated with the Nurses Association of Northern European Countries, including Denmark, Sweden, Iceland and Finland, and, of course, the International Council of Nurses. The chief duties of the NSF are to supervise the training of student nurses and to work for better working and living conditions for its members. Ill and needy nurses are provided for by a special NSF fund. The NSF also maintains a professional library and publishes a bimonthly journal called *Nursing*. Together with other Northern countries it is working on the improvement of nursing procedures.

The exchange of nurses with those of other countries is also arranged by the NSF. Norwegian applicants for such scholarships must have a working knowledge of the language of the country where they intend to work and study. Since Norwegian children begin to learn English in grammar school, it is not at all difficult for a Norwegian nurse to study in America. But it is certainly not easy for an American nurse to go to Norway and learn the language. As far as I know, only one American R.N. has had the courage to face this problem and arrange to study under a Fulbright scholarship. She not only finds this experience stimulating and interesting, but she has been received with much friendliness by her hospitable Norwegian colleagues.

Although I have never worked in a Norwegian hospital, I have observed the nursing techniques. I have visited several nursing schools and sat in on their classes, and most impressive of all— I have had a baby in Norway. From my observations of Norwegian nurses, it seems to me that they are, on the whole, fine and well-qualified women. Because most of them come from devout Christian homes, nursing to them is not merely a way to make a living; it is their vocation and a specific call to help mankind. I have found that the morale of Norwegian nurses is usually at a high level. This I attribute to the fact that they are not as perpetually overworked as American nurses, even though they still have a 48-hour week. Of course, they have their busy times, too, but there is less pressure, and not such an acute nursing shortage. Also, the subsidiary workers, of whom there are very few, seem to be of a high caliber which may be a result of good personnel policies.

"Always be ready," reads the front cover of the *Nursing* journal. One is reminded at once of the Norwegian nurses' main duty. The NSF pin also symbolizes this readiness to serve. On it are many clouds, a little bit of blue sky, and the sun breaking through. In Norway, as I have found, the sun is always ready to shine through the [*Continued on page* 62]

SUMMER COOLERS

by Francia Hughes

• In July, when wilting R.N.s take to the sea or sun, the most up-to-the-minute mermaids will be wearing these Jantzen land-and-water cottons. One, the new-looking shirt-tail suit, left, is in white piqué, inner-lined, of course, with auxiliary straps for the bare-topped bodice, $10.95. The other, right, a halter-suit of white piqué, fits like a well-made dress, thanks to its buttoned bodice and zippered, elasticized back, $12.95. Both come in colors, too, contrast-trimmed.

• Clever! This strapless, Cole of California sunback dress of knitted polka dot terry cloth that turns into a hooded beach cape before you can say "convertible" out loud. It'll more than pay its way at $17.95.

The Inside Story

● In summer, when every strap's a nuisance and every layer of lingerie's a load, Gilead whips up a washable white cotton bra-slip that must have been invented for nurses! Cleverly contoured and front-zipped, it curves with you. The secret? Body-moulding elastic inserts, feather-boning, flared skirt, and A, B, C cups. Cotton ($5); black nylon ($8.98).

● To awake refreshed, sleep cool in the crisp, white cotton plissé "Tommies," below. Pajama-suit, $4.95; and finger-tip coat, $3.95, travel well together on summer vacation.

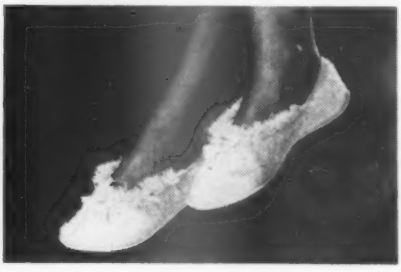
The Outside Story

● For a fading R.N., yearning at day's end to shed her starchy uniform for a pretty summer "cooler," we prescribe the cotton "Turnabout" by Royal Robes. Over your head it goes, wraps, ties and—presto!—without hooks, buttons, zippers, or fuss, you're dressed for your public in one of four different ways shown here. This cotton madras "Switcheroo" washes like a breeze, costs $8.98 at Franklin Simon, N.Y.

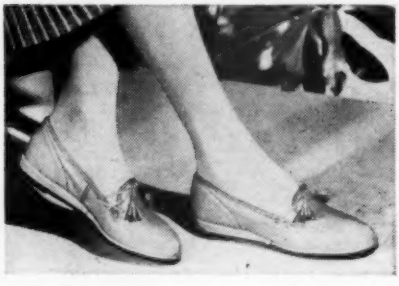
For names and addresses of stores across the country carrying items you want, write makers listed on page 98.

Shop Talk

◀ The blouses you live in all summer long, when not in uniform, should be cool, pretty, and ready to top either your skirts, shorts, or slacks. They must also be well-cut, well-tailored, and on easy terms with the tub. Ship'n Shore's gay cotton trio take the prize on all counts, though their tiny price tags belie their big talents: the off-beat plaid, $3.50; the beautiful broadcloth or the sizzling stripes, $2.98 each.



Devotees of Donna Fenlason's "Lacy Susans" for the boudoir, demanded "Terry Susans" for beach and bath. The soles wash; they have foam rubber inner soles, fold into a terry bag. $4.95 at Bruck's Shops. ▶



◀ You'll be glad Jantzen turned shoemaker when you try on their "Zurich," new, soft, glove-leather wedgie. Best in "Benedictine," it sports a high-rise vamp, soft toe and heel, elasticized laces. Under $10.

▶ Want the perfect bag for summer dresses? It's Alan's "Butterfly Net"—a deep, catch-all of clear plastic, sheathed in bright or white fishnet and squared at the bottom to sit as well as it swings from your wrist or shoulder, $10.50. And if you want to add a cool frosting to summer clothes, wear Coro's chalk white beads at your wrist and neck, wonderful on black.

Nurses Make Good Neighbors

by Frances Lewis, R.N.

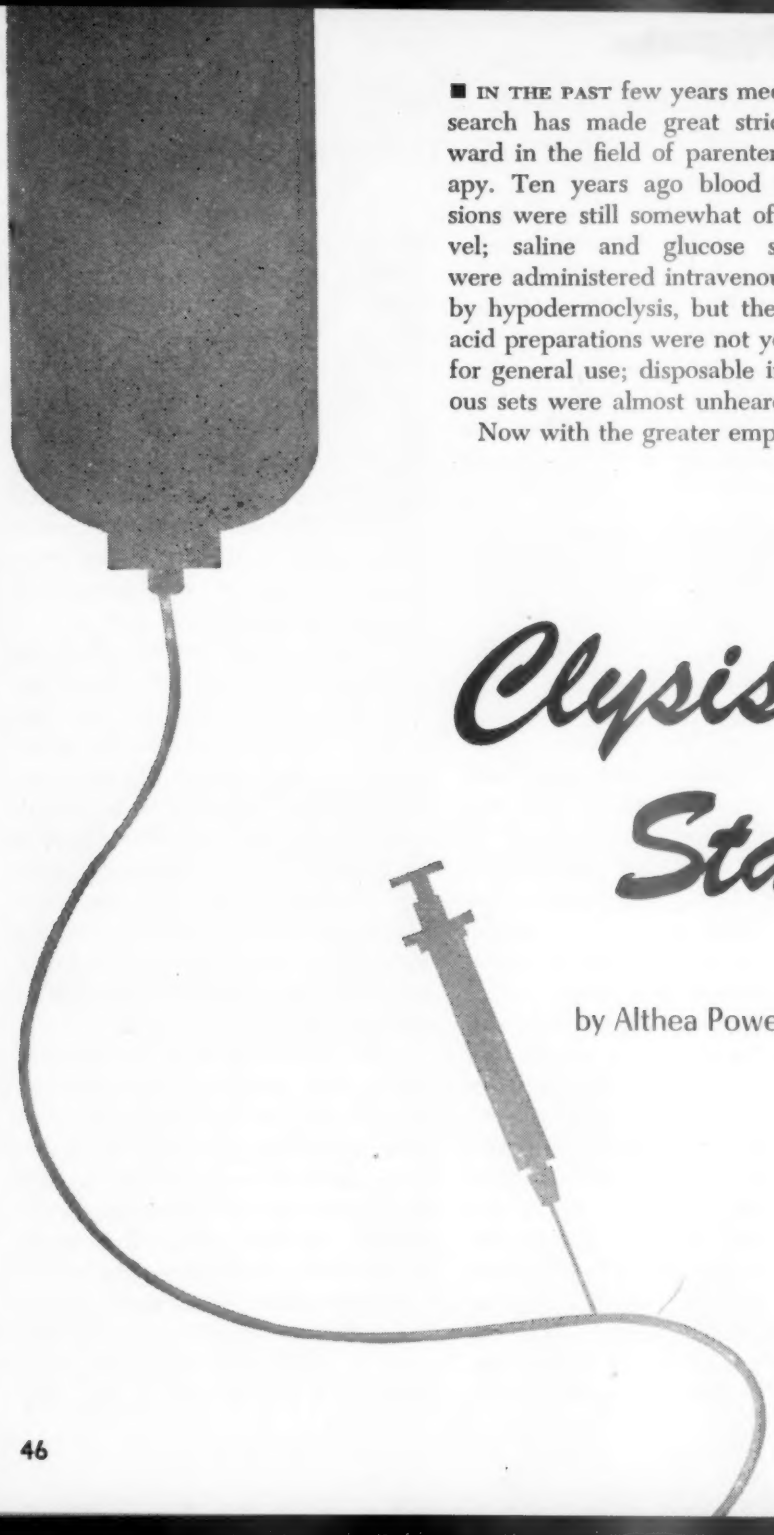
■ A NURSE, or for that matter, anyone working in a great metropolis is apt to feel like a mighty small cog in a large wheel. This feeling is further intensified when illness strikes, leaving the victim physically and sometimes financially stranded in a lonely apartment or an impersonal hospital room. Impressed with the number of instances in which their fellow employes found themselves in this predicament, a group of enterprising nurses at a large hospital in New York City decided to do something about it. Although they could not bear the entire expense of a nurse's illness, they believed that the least they could do was to lighten the sick nurse's burden. With this objective in mind, they formed, on March 18, 1949, an organization called the Good Fellowship Club with the stated purpose of uniting nurse members "in a spirit of friendship and mutual assistance."

To obtain money for the new venture, a raffle was held which provided ready cash for the necessary stationery and bookkeeping materials and a starting fund for the Club's activities. In addition, each member was required to pay an annual fee of $6. Membership was, and is still, restricted to registered professional nurses on the staff and to the private duty nurses who work at the hospital.

Although 159 nurses joined the Club during the first year, several of the nurses were reluctant, advancing the argument that they "already had insurance" and they didn't see what the Club could do for them. Later, when they saw how the Club functioned, many of these unbelievers changed their minds. Actually, the Club is not an insurance scheme, even though members may be urged to avail themselves of insurance. More often than not, it has been found, nurses are not adequately insured against illness.

When the Club first started, books and flowers were given to sick members, but soon it was decided that gifts of money would be far more useful and appropriate. At the present time it is the policy to send varying amounts under $25 to nurses who have been sick in the hospital or home for two weeks. If a member's illness prevents her from working for a longer time, the check is made out for a larger sum—at times for as much as $100.

Often the Club pays for services rather than giving money directly. A nurse who needed cortisone injections, when this drug was so expensive, received a "gift" of several doses. After her recovery, she was so grateful that she donated a radio to the Club, which promptly raffled it off for $450. Occasionally, members refuse to accept money. In one case in which this happened, the adroit Club [*Continued on page* 60]



Clysis Stat.

by Althea Powers, R.N.

■ IN THE PAST few years medical research has made great strides forward in the field of parenteral therapy. Ten years ago blood transfusions were still somewhat of a marvel; saline and glucose solutions were administered intravenously and by hypodermoclysis, but the amino-acid preparations were not yet ready for general use; disposable intravenous sets were almost unheard of.

Now with the greater emphasis on

parenteral therapy, nurses are becoming even more aware of the need for knowledge of the techniques involved. The injection of fluid other than by way of the alimentary canal is known as parenteral therapy. The two most common ways of doing this are subcutaneously by hypodermoclysis and intravenously. Recently fluids have been administered intra-arterially and intra-osseously. Needless to say these procedures must be carried out with strict aseptic technique and an order for one or the other galvanizes a nurse into action.

Solutions most commonly used for parenteral purposes include physiological or normal saline which is 0.85 per cent sodium chloride, 5 per cent and 10 per cent glucose in saline or distilled water, Ringer's solution, amino-acid solutions, plasma and blood. Salts and in some cases plasma proteins are lost along with water when the fluid loss is great. Glucose, amino acids and vitamins must be supplied when the patient cannot obtain adequate amounts of these substances orally.

The major factor in determining the amount of parenteral therapy needed by the patient is the relationship between the patient's fluid intake and his output. Not among the least of the nurse's responsibilities is the keeping of accurate intake and output records. Ordinarily, the intake and output of the body during 24 hours balance each other at approximately 3,000 cc. This does not mean, however, that a person drinks 3,000 cc. of fluid during a day and voids 3,000 cc. of urine over the same period of time. Water is present in varying amounts in every gram of solid food eaten and additional water results from the oxidation which occurs during metabolism.

The average urine output may be from 600 to 2,000 cc. Additional fluid loss, the so-called insensible loss, results from evaporation of water from the skin and exhalation of water from the lungs. From 50 to 400 cc. of water is lost through the digestive tract. In order that the waste products of metabolism may be held in solution, "fluids should be given in such amounts as to cause a urinary output of between 1,000 cc. to 1,500 cc. The only accurate way to maintain fluid balance is to know the exact amount of intake and output."[1]

When an excessive loss of fluid occurs or if the patient is unable to take an adequate amount of fluid orally, this deficiency must be made up. Extensive loss of fluid may result from hemorrhage, toxemia, diarrhea, and persistent vomiting. There may be an exodus of fluid into the body cavities, the tissues or the skin as in peritonitis, empyema, severe burns, or shock. Where the Wangensteen or similar suction apparatuses are used, fluid equivalent in kind and in amount must be supplied to replace the fluid withdrawn.

Physiological (isotonic) saline is given to supply sodium and chloride ions to the body. Ringer's solution and other similar solutions which contain potassium and calcium electrolytes as well as sodium and chloride may be substituted by the doc-

tor for saline solution, particularly in instances of persistent fluid loss as in prolonged vomiting.

Amino acids are often given preoperatively as well as postoperatively to build up a protein reserve in the body, and are indicated where there is malnutrition, danger of shock, or leakage of plasma. When the body protein is low, tissue regeneration, the formation of red blood cells, wound healing, repair of fractures, resistance to liver-damaging substances, gastro-intestinal motility, antibody response, and normal fluid distribution are all impaired. Usually the amino acids are supplied in conjunction with a 5 per cent solution of glucose either in water or saline; the glucose is utilized for energy leaving the amino acids free to combat the hypoproteinemia.

Once a flask of amino-acid solution is opened it should be used immediately or discarded, for these solutions are excellent culture media for bacteria. Cloudy solutions are never used. If the patient complains of feeling warm and his face seems flushed, decreasing the rate of flow of the solution will probably cause these symptoms to disappear. Reactions are infrequent although there may be some nausea.

Although all of these solutions may be given intravenously, only solutions which are *isotonic* may be given with any great degree of safety by hypodermoclysis. "Solutions developing the same osmotic pressure as the blood are called *isotonic* with the blood; those producing less than the blood, *hypotonic;* those producing more, *hypertonic.*"[2] Elman states, ". . . types of fluids which can be injected in this way [by hypodermoclysis] are limited to isotonic saline, 5 per cent glucose in water, and certain solutions containing amino-acid mixtures, glucose, and salt in amounts not to exceed twice the osmotic pressure of the blood . . . solutions other than isotonic salt must be injected with caution and with full knowledge of the potential dangers."[3]

A hypodermoclysis is usually given when the main object is to increase the tissue fluid and it may also be chosen for young children with small veins and for older persons whose veins have sclerosed. The most usual site for this therapy is the anterior surface of the thighs. However, the loose tissue under the breasts or the abdominal wall above the iliac crest may also be selected. In children, the area over the latissimus dorsi is sometimes used.

Hypodermoclysis

In the administration of parenteral therapy, cooperation between doctor and nurse is of the utmost importance. Regardless of whether the doctor or the nurse finally inserts the needle, the nurse must be able to assemble the equipment and prepare the patient for the infusion; it is the nurse who must watch for any untoward reactions and check the apparatus for mechanical difficulties which may arise while the infusion is running.

Sterile clysis set-ups as well as the solution needed may be obtained from central supply in most hospitals.

Before opening the solution bottle it should be tested to see if it is still hermetically sealed. This is done very easily by the use of the "click" test. If a vacuum still exists in the bottle a sharp metallic click will be heard when the flask is struck a gentle blow with the fingers. After checking with the doctor and with the label to be sure the solution is the correct one, remove the metal cap from the flask and insert the vent tubing in the bottle. Hang the bottle from the standard, flush the tubing to drive out the air and reclamp the tubing.

It is no longer deemed necessary to warm the solution before administration. Room temperature is now judged to be the optimum temperature regardless of whether the fluid is to be given by clysis or intravenously. The sight of clumsily fastened hot water bottles flanking the solution containers in an effort to keep the fluid warm has disappeared from the wards.

The patient will be most comfortable on his back with neck and knees flexed. A folded bath blanket is placed over the upper part of the body and the upper covers are folded back far enough to expose the thighs; sterile towels may be draped over the bed clothes above and below the area of injection.

The doctor will insert the needles after the area has been cleansed with alcohol or some other suitable agent. A fold of skin is pinched up with thumb and forefinger, and the needle is inserted to its full length. The tip of the needle should lie just below the surface of the skin in the loose fatty tissue found there. If procaine is to be used it is injected intradermally, and the clysis needles are inserted through the wheals that are formed. If no blood appears in the clysis tubing, indicating that the needle is not in a vein, the tubing may be unclamped. If the needles are put through gauze squares before insertion, a cushion is provided for the hub of the needle to rest on. When the clysis is finished the needles are [*Continued on page* 68]

YOU COULD BE RIGHT

My Tabby yawns in deep content,
Her mewing brooks no argument,
Her amber eyes seem innocent
And ages old.

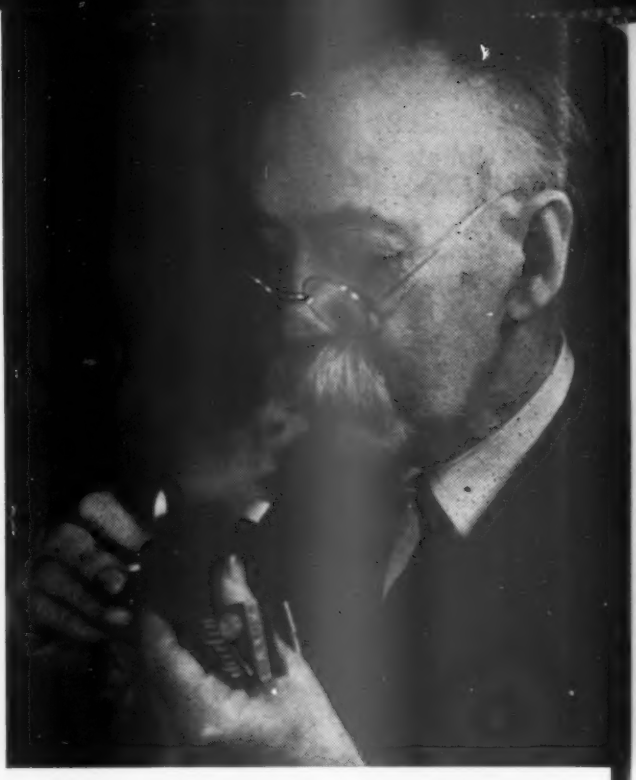
The guileless pleading in her face,
Her stride of pure, unhurried grace,
The hint of tigress in her pace,—
I envy those.

Yet, if you think no loftier
Desire is mine than cleaning fur,
And, after dining well, to purr,—
You could be right . . .

—Sylvia Storla Clarke, R.N.

Skin Problems of the Aged

by
Herman Goodman, M.D.



■ OLD PEOPLE have many of the same skin ailments as young people, for old age in itself does not confer immunity to the diseases of the young. Also, the skin of many older people, although entirely normal in every other respect, may itch sufficiently to cause scratching, rubbing, or scraping. Changes in the weather, in types of clothing, in moisture, may accentuate the cause of the scratching. Certain skin areas are sites of itching and scratching more than others. In the absence of any definite etiologic condition, such as scabies, diabetes, allergy, lichen planus, or jaundice, one must label this condition "senile pruritis."

The chances of dying from cancer of the skin are low, in the neighborhood of 30 per 1,000 cancer deaths. However, it is wise to remember that almost any growing or changing disfigurement of the skin *may* be cancer. Older persons must have a high index of suspicion of such growths and nurses must urge them to consult a doctor for diagnosis and treatment.

The chief skin problems of the aged may be summarized under various headings.

¶ One problem of the aging person concerns *baldness*. Men may ignore their receding hairlines and bald pates but usually the mature woman worries over a loss of hair. This symptom of old age has no discoverable immediate cause and, unfortunately, cannot be alleviated; it is a part of idiopathic baldness or

alopecia. The aged person rarely recovers the hair of youth. Loss of hair in spots, alopecia areata, may affect the scalp, the region of the beard in males, and the hair in the axilla and the groin. Persons undergoing treatment with the cortisone type of hormone have shown regrowth of hair in the normal scalp pattern. Women may have undesired hair growth on the chin, cheeks, and upper lip.

¶ *Graying of the hair* is also accepted as a sign of old age, although some persons are gray in childhood and others become prematurely gray in the decade between 20 and 30. Gray hair is simply hair without pigment. Contrary to popular notions, hair does not "turn" gray; it grows out of the scalp that way.

¶ *Wrinkles* are considered an indisputable sign of aging, though they may not necessarily be so. Actually, wrinkles are minor excesses of top or scurf skin or epidermis with indentations. Causes of wrinkles include loss of firm dermis or true skin, and of the elastic qualities of the supporting tissue. The reduction of body weight, the atrophy of supporting connective tissue at bends and folds on the body lead to leanness of the part and wrinkles. The crepey neck of the woman of advancing years is an excellent example; baggy eyes are another instance. Loss of liquid from the areas about the eyes, the mouth and neck predisposes to wrinkles of these areas.

¶ Another sign of old age is a *thin smooth skin*. The thin skin of the aged person is dotted with accumulations of pigment. The veins under the skin appear enlarged and the blood within them appears blue. The entire body, particularly covered surfaces, shows the scaliness of this skin. Rubbing the nude skin causes a shower of scales to fall.

¶ Strange as it may seem, the appearance of large, curled, dark, fragile *toe nails*—particularly the nails on the big toes—is really atrophy, not hypertrophy. The nail plate or the nail matrix is atrophied. The nail is only retained horn, piling up not unlike the scales of the thinned skin of the older person.

¶ Men and women past 40, and some younger in years but old physiologically, have redness localized on the skin of the nose and the skin close to it. Some have enlargement of small skin vessels. In this condition, *telangiectasia*, little red lines run off in every direction like spokes on a wheel. The true cause of this is aging of the skin, and lack of support of the blood vessel walls permitting them to engorge because of atrophy of the connective tissue. Many persons approaching old age present little dome-shaped red spots on the skin.

¶ The space on either side of the older individual's nose is a favorite site of one form of *seborrheic dermatoses*. Other areas of the skin present accumulations of scales that are greasy to the touch. The scales, often dark in color, are easily removed. However, the base soon reforms the same soft warty excrescences.

¶ The skin of old people may show collections of color. Some are called liver spots, [*Continued on page* 67]

Convention News

OPERATION MERGER

✓ The five-day convention schedule at Atlantic City, N.J., June 16-20, was strenuous, and at times weather and tempers grew hot, but by the end of the week Operation Merger was completed. With some modifications, including one that prohibits a non-nurse from being a first vice-president of the NLN, 406 NLNE members voted to adopt the new purposes, bylaws and name to create the National League for Nursing. Three members in attendance were opposed to this action. In the NOPHN, with 4,607—about half of the membership—voting dissolution, only one registered disapproval. The ACSN was dissolved by its board of directors early in the week.

40-HOUR, 5-DAY WEEK

✓ The 40-hour, 5-day week was urged for all nurses—without reduction in present salaries and with time-and-a-half for overtime—in a resolution to the ANA House of Delegates endorsed by the General Duty, Private Duty, Administrative, and Industrial Nurses sections. Every nurse was called upon to work through the local sections, district, and state nurses associations for the immediate implementation of this resolution. The house of delegates wholeheartedly endorsed the principle and, surprisingly, the opposition anticipated from the Administrative Nurses section did not materialize.

Originally, the 40-hour, 5-day week resolution was intended for the country's general duty nurses working in hospitals, who, according to a convention release, number 86,000. However, the private duty nurses went on record as wishing to promote the 40-hour week for their group also. Another resolution from the Private Duty Nurses section stated in effect that when private duty nurses are available, the private duty nurses of the ANA deplore the practice of other employed nurses using their two days off to take private cases. This, in the eyes of the private duty section, is an "insidious" practice. The section requested the ANA Board to inform the AMA and AHA of this resolution and to secure their cooperation in carrying it out.

ANA PLATFORM

✓ Economic security was also stressed in the 19-plank platform adopted by the ANA, with one plank calling for improving working conditions

through strengthening economic security programs, using group technics, including collective bargaining, and through supporting desirable labor legislation which affects nurses. Previous stands of the ANA were reiterated by resolutions reaffirming the right of nurses to make their own decisions as individual citizens "regarding any prepaid health and medical care plan which is consistent with the basic ANA policy of promoting and improving nursing care for the American people," and continuing promotion of legislation for the commissioning of men nurses in the armed forces.

THE NURSE DRAFT

A nurse draft, if needed, is not to be opposed but supported by the ANA, voted the house of delegates in the last ANA business meeting. Following the request of Mrs. Elizabeth K. Porter, ANA president, for guidance in any national emergency that might occur between Biennials, the delegates, by a majority vote, authorized the board of directors to take this action for the nursing profession.

DUES INCREASED

In the ANA House of Delegates, discussion of structure and revisions of bylaws occupied the greater part of the time of the 1,628 delegates in four of the five ANA business meetings. The most important revisions were a $2 increase in national dues, a change in proportional representation based on sections rather than state, with representation in the House reduced from 1-100 to 1-200. The new ANA functions now limit the Association to promoting legislation and the general welfare for nurses, standards of nurse practice, and acting as national spokesman for nurses with allied professional and governmental groups and with the public. Action on organized nursing service and nursing education, formerly the responsibility of the ANA, NLNE, and NOPHN, has now been assigned to the new organization, the NLN.

NEW SECTIONS

In a general reorganization of sections, the Men Nurses and the Federal government sections were dissolved, and three new sections, the Public Health Nurses, the Educational Administrators, Consultants and Teachers, and the Special Groups, were created. The respective chairmen of the new sections, Mrs. Fannie T. Warncke of Calif., Fausena Blaisdell of Pa., and Mrs. Mary C. Walker of Col., automatically become members of the ANA Board of Directors for a two-year term.

Newly-elected section chairmen of the existing sections are Mrs. Mina Kenworthy of Calif., General Duty section; Miriam Robider of Md., Private Duty Nurses section (re-elected); Evelyn Hamil of Okla., Administrative Nurses section; Mrs. Fannie Milliken of Pa., Industrial Nurses section.

ANA ELECTIONS

Nominated from the floor for the ANA Board of Directors were Dorothy Wheeler, of Washington, D.C.; Anna D. Wolf of Md.; and Margaret Gorey of Ky. Mrs. Alice Kauffman of Pa. was also a candidate from the floor for the Nominating Committee.

Re-elected officers of the ANA include Mrs. Elizabeth K. Porter of Ohio, president and Agnes Ohlson of Conn., secretary. Also elected were Mrs. Lillian B. Patterson of the state of Washington as first vice-president; Mabel Montgomery of Va. as second vice-president; and Annabelle Peterson of Washington, D.C. as treasurer.

Mrs. Myrtle C. Applegate of Ky. was re-elected as a member of the ANA Board of Directors. Other new directors who will serve for four-year terms are: Janet M. Geister of Ill., formerly first vice-president; Mrs. Mary Mesecher of Iowa, formerly General Duty Nurse section chairman; and Margaret Filson of Minn. Elected to the ANA Committee on Nominations were: Marion Alford, Calif.; Mrs. Ruth Coe, Wis.; Mrs. Nola Sheldon, Wash.; and Mrs. Alice Kauffman, Pa.

NLN ELECTIONS

At the first meeting of the National League for Nursing on the last day of the convention, the 1952 initial board elected from a fixed slate was presented to the membership. President of the organization composed of professional nurses, non-nurses, and agencies is Ruth Sleeper, R.N., former board member of the NLNE, and director of the school of nursing at Massachusetts General Hospital. Other officers elected by the newly-formed Board in a brief, behind-the-curtain conclave were first vice-president Frances C. Thielbar, R.N., of Ill.; second vice-president Mrs. Arthur O. Spiegel of Ill.; third vice-president Dorothy Wilson, R.N., of Conn.; and treasurer L. Meredith Maxson of N.Y. The appointment by the Committee on Agreements of Anna Fillmore, R.N., of N.Y. as secretary and general director was approved by the Board.

The 24-member board of directors also includes Emilie G. Sargent, R.N., of Mich.; Agnes Gelinas, R.N., of N.Y.; Elizabeth S. Bixler, R.N., of Conn.; Frances J. Brown, Ph.D. of Washington, D.C.; Julia Hereford, R.N., of Tenn.; Sister Charles Marie, R.N., of Tex.; Dr. George B. Darling of Conn.; Willie Mae Johnson, R.N., of N.J.; Olive W. Klump, R.N., of Calif.; Mrs. H. Stanley Johnson of Wis.; Henrietta Doltz, R.N., of Ore., Mildred I. Lorentz, R.N., of Ill.; Mrs. Genevieve Bixler of Iowa; Dr. E. Dwight Barnett of N.Y.; Mrs. Carl C. Avon of Ga.; Elaine Mashburn of N.C.; Marie Peterson, R.N., of Minn.; George Mason, R.N., of Md., and Winifred Cushing of Wash.

PRACTICAL NURSES AND THE NLN

One of the problems facing the new organization—the admission of practical nurse members—was temporarily solved when NLN members approved in principle the inclusion of qualified practical nurses in the NLN, and instructed the NLN Board to appoint a committee to work with appropriate practical nurse groups to submit recommendations on practical nurse membership at the next annual meeting.

THE STUDENT COUNCIL

In contrast to the compliance of graduate nurses with the proposed structure plans, students rejected offers of both the ANA and NLN to become a council or councils in one or both of these two organizations. Instead, over 1,000 students representing 43 states and two territories made the independent decision to form a national student council under the sponsorship of the Coordinating Council of the ANA and NLN. Carolyn Kuesher, a student at the Presbyterian Hospital School of Nursing, Pittsburgh, Pa., was acting chairman of the student group at this Biennial.

NEWSLINGS

Despite the prediction of 10,000 registrants, the final count was 8,678, including delegates from every state, Washington, D.C., and the territories of Hawaii, Puerto Rico, and Alaska . . . The Alaska Nurses Association was officially recognized at an ANA House of Delegates meeting as the 52nd affiliate of the ANA . . . The Mary Mahoney Award for outstanding contributions in the field of intergroup relations was presented to Mrs. Marguerette Creth Jackson by Mrs. Mabel K. Staupers, former president of the recently dissolved NACGN. Mrs. Jackson is assistant supervisor of the Visiting Nurse Service of New York.

POST-CONVENTION ACTIVITIES

On Saturday, June 21, editors of state nurses association bulletins and public relations personnel gathered for their second Biennial conference to listen to the experts and thrash out mutual problems. The all-day meeting presided over by Mrs. Dolores Colesworthy, chairman of the ANA Public Relations Committee, featured a panel discussion and a talk on techniques of writing by Roscoe Ellard, professor of journalism at Columbia University, and author of "Editing the Nurses' Bulletin," a new ANA publication. All attending the meeting agreed that a workshop for bulletin editors should be held in the near future.

A state reorganization conference sponsored by the NLN Committee on Agreements, in cooperation with the ANA and the Joint Coordinating Committee on Structure was scheduled for Sunday, June 22, in order that constituents of the merging national nursing organizations might discuss reorganization on the state level.

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*Sources available—for further information write
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390 Park Ave., New York 22, N. Y.

Chlorodent CONTAINS ACTIVE CHLOROPHYLLINS

[*Continued from page* 30]

of the other recent articles I've written. No subject can bring such attentive, sympathetic response from a nurse audience then the subject of good patient care. We can go anywhere, hamlet or metropolis, and find nurses bursting to talk out their concern over "what's happening to nursing." It takes worry and threatened loss to make us realize what are the things we hold dear. We cannot attribute all of our failure to make "normal" gains in association memberships to the indifference of individual nurses.

When General Ridgway took over the Pacific Command he went out to his troops and asked, "What do you know that can help me do this job?" It is that attitude and method that helps provide the soundest answers. The ideas and experiences of the nurse on the job are quite as valuable as are those of the nurse at the desk. Their responsibilities and approaches are different but their blended conclusions form a whole. We must hitch those disconnected constructive ideas to purposeful constructive action; that means providing a way for nurses to express their ideas. I go about exhorting nurses to "join up and help," yet I am always aware of the inadequacy of our methods of utilizing their help and their suggestions.

To be sure, members of our associations can vote in elections and on major programs and policies, but where can the average nurse express himself or herself on present trends and some needed corrections? And who is asking the nurse to do so? Nursing, like a lot of things, is suffering from bigness. The bigger the organization or profession, the smaller becomes the individual. That is why nothing is more important in keeping a profession moving forward than open channels of communication between its policymakers and its members. We are doing much better today than in the past in *telling* the members what is going on—now we have to do much better in *asking* them too. Presumably the district association furnishes the nurse with a sounding board, but does it? The present pattern of district programs was established before we had a sizable number of magazines, bulletins, textbooks, and manuals to keep us abreast of medical developments. But we still lean heavily in our programs on medical and similar lectures, with one person doing all the talking and everyone else just passively listening.

There are signs that nurses are trying to create their own methods of pooling ideas and ideals. In one state I was told there were twice as many little unattached nurses' clubs as districts. Recently a county nurse asked me to meet with such a group, an intelligent lot of young women. Most of them were married nurses who help out in their local hospitals on numerous occasions. Not one belongs to the district association! Said one, "Going to district meetings means driving from 20 to 40 miles to hear reports and a lecture on

allergy, which we can read at home in our nursing magazines. Or there's talk on structure or economic security and such. You spend too much time on those things and not enough on our main interest, good care for our patients." A few weeks ago I went out to speak at a district meeting. Hostesses for the day were members of a local nurses' club, and again not one was a member of the district, though they are on excellent terms with the nurses who are. I learned of two other similar clubs in neighboring towns.

We are strong only as our organizations are strong. We cannot mobilize our full powers if any appreciable number disperse into islands of clubs unrelated to a main body. The fault lies not with the club members who seek an outlet for their yearning, but with us for not providing that outlet. The decisions and plans for nursing that will pass the tests cannot be made at the top or bottom of nursing, but *through* it. We must recognize and meet the need for a direct way of tapping and utilizing the rich well of ideas and ideals of nurses in every rank.

There is a wealth of sound judgment and ideals born out of experience in our great tier of middle rank nurses. "The best gardens are those whose proprietors get down on their knees to plant," says a *New York Times*' editorial, and my neighbor who raises wonderful roses, adds, "That's right! I read the garden books and magazines, and I study catalogues all winter. But I learn most about flowers from getting right down on my knees with them." We can't go far wrong when we stay close to the people who every day *have* to make good on their jobs. We hear a good deal, "Have faith in your leaders!" That is right, but we should add, "and leaders have faith in your followers, and together keep the faith."

An able, young hospital supervisor dropped in recently to say, "When I first took the job I was surprised at the reluctance of some of the young nurses to give rounded care. They seemed to prefer the special jobs like medications. Then I realized they didn't know how to round out patient care. We started classes and put more responsibility on them. They took to it like ducks to water! Come and see us. You'll be surprised at our low staff turnover, and how much work we get done through planning and having the aides help in the right places." This supervisor represents a broad layer of nurses whose experiences and attitudes give weight to their opinions. They get down on their knees in the garden and learn the facts of life.

We are all in this together. We need all the ideas and wisdoms we have. Those of the "little people" must be blended with those of the top policymakers who must survey the whole field objectively and plan for the profession's total needs. Our greatest unity can come only if we kneel together in the garden. It is the rare soldier who can go to the General, but the General can go to the soldier and ask—"What do you know that can help me do this job?"

Good Neighbors

[*Continued from page* 45]

hurdled the barrier of "pride" by sending groceries instead of a check. Club members are also proud of the fact that they now have their own blood bank. Financed with money obtained through the sale of Christmas cards, blood in this bank is reserved for members whenever they need it.

Provision of money and medical services, however, is not the only evidence of the Club's good fellowship policy. Realizing that friendliness and the knowledge that someone cares play a large part in a patient's recovery, a weekly letter is written by the Club secretary to the sick nurse, and the trustees of the association make frequent visits.

Although the Club is not incorporated, it has a set of bylaws and rules and regulations. There are 16 trustees, including the president, vice-president, secretary and treasurer, and an assistant secretary and treasurer. The bonded treasurer, who serves as custodian of the association's funds, signs and endorses the checks which must also be signed by another officer. The matter of distributing funds is handled by the board of trustees which meets once a month to discuss each individual case. The members themselves gather once every three months for a combined dinner-business meeting.

Financially speaking, the Good Fellowship Club is considered a success. This year, after three years of operation, it can boast of a balance of $2,800, as well as substantial "credit" in the blood bank. Even more impressive is its record of $3,000 spent in gifts to sick nurses. Because the Club is exclusively for nurses at this hospital, nurse members do not go out of their way to publicize the program to outsiders. However, patients who do hear about the organization express interest in it and sometimes donate money. The record membership of 210 for 1951-1952 also speaks eloquently for the popularity of the plan. Nurses at the hospital are convinced that their idea is a good one and could be carried out in many other hospitals, especially those in large cities where neighborliness can be a rare commodity.

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Nursing in Norway

[*Continued from page* 40]

threatening clouds and give warmth to a cold and rather desperate world.

There are several nursing "societies" in Norway for the deaconesses, the Red Cross sisters, the nurses of the Norwegian Women's Public Health Association, and finally the so-called "parish sisters." The latter, who have no counterpart in America, have a special education as visiting nurses and parish workers and are then employed by the voluntary parish aid societies in local congregations. All of these nurses have their own uniform; a few even wear an outdoor uniform. Members of the NSF have their own special uniform, too. Depending upon the school of nursing, an insignia is worn on the left arm, and the NSF badge is proudly pinned over the heart. The indoor uniforms of most hospitals resemble our American student nurses' uniforms.

Most refreshing is the Norwegian nurses' talent for interior decorating. Never before have I seen such lovely rooms in nurses' homes. They are complete with modern furniture, handmade pieces of Norwegian folk art, and many, many plants and flowers. The homes which I visited had fully equipped kitchens where nurses cook and bake whenever they wish. When I was last in the hospital, it was just before Christmas and I saw several nurses in big kitchen aprons turning out the most delicious cookies—for their patients. Their ingredients came from the main kitchen, free of charge. Every room in the hospital had Christmas decorations, and every patient had his little tree. How American patients would envy this.

All hospital workers, nurses included, have hospitalization and sickness insurance, and very often a pension plan. This also applies to public health nurses. As a matter of fact, Norway has an old age pension (from 70 years on) for every citizen. As a result, nurses do not have to spend the best years of their lives making money for their old age. Some nursing "societies" take over the complete responsibility of their ill and aged nurses. Nursing as a profession is considered very honorable, and the public has great respect for its members.

Packing Tips

[*Continued from page* 31]

plastic containers for convenience.

A bottle of non-inflammable spot remover is indispensable when traveling. A drop of salad dressing could slip from your fork, but when you remember the bottle of spot remover, your dismay is quickly dispelled.

A tube of cement is useful in unexpected ways. We still remember that repaired porcelain candlestick in a hotel room in Sweden.

Of course, you will take a sewing kit packed with threads, needles, pins, snappers, and various little items. A bag with drawstrings takes up less room than a box. Those hard corners are always in the way.

Glasses—an extra pair. The ones you are wearing might meet with a mishap. Also remember a pair of dark glasses.

General Advice: Keep on hand that important state of mind called alertness. Use it as a watchword. Check your tickets twice. The second time you might get vital information that somehow had slipped by you before. In driving, valuable time can be saved by checking for information. The unexpected looms up so quickly that all one can say is—It's a big asset to be alert.

Above all, Friend Traveler, hang on to your sense of humor. The grasp may need to be firm at times. Someone has said that, next to love, humor is the greatest solvent in the world. Smile at the policeman who has just stopped your automobile and asked you to pull over to the curb; at the customs officer who would stir up the contents of your suitcase with a puddling stick; at the hotel clerk who tells you he hasn't a room left. All hotels hold back reserve rooms. So work on him.

These suggestions may need to be modified to suit individual needs, but thoughtful preparation for your journey is a great help in sending you off to a smooth start.

Murphysboro (Ill.) doctors operated on three-and-a-half year old Jimmy Gallo for what they thought was appendicitis—and found two huge wads of rubbery bubble gum were the source of Jimmy's very troublesome ache.

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Skin Problems

[*Continued from page* 51]

but few are actually connected with diseases of the liver. Pigment (melanin) collects on the forehead, for example, close to the hairline. Small spots soon enlarge and protrude above the surface. For the most part this *hyperpigmentation* is harmless and does not become cancerous.

¶ Little *cutaneous tabs* of skin appear as another definite sign of age. The loose skin of the neck and other parts, as the armpits and groin, show numerous annoying and disfiguring projections of skin color or slightly darker hue. Cutaneous tabs are easily removed, but reappear.

¶ The older person's skin, particularly on the face, has a *yellowish cast*. This is believed to be due to changes in the elastic tissue cells which are held in bundles or networks. Other changes of the skin, such as the apparent enlargement of the sebaceous sacs, accentuate this yellow hue. Enlarged apertures on the skin surface from the sebaceous sacs appear as *enlarged pores*. *Yellowish, flat, soft papules* appearing under the eyes are due to cholesterin changes or accumulations and may indicate degenerative cardiovascular disease or diabetes. The curious yellow plaques, due to the chemical failure in lipid and sugar metabolism, require removal by surgery. Dietary changes sometimes help, also.

Older people frequently have brownish or black wartlike growths on the skin. The face is often the site of these old age warts or *senile keratoses* which may appear on any part of the skin surface. The differentiation of the harmless senile wart from cancer requires careful medical and laboratory examination.

Geriatrics Guide

• Worthy people, intent upon doing good, frequently visit hospitals and homes for the aged. They bustle in, halos a-glistening, eager to interest our senior citizens in a new hobby—in doing something with their hands. One discerning glance at those tired old hands would show that they are generally content to be idle after a long lifetime of "doing something." Nothing we can offer intrigues the older person more than his own memories. If anticipation is greater than realization, retrospection, as indulged in by the aged, is the same thing in reverse. Listeners' clubs would be a delight to the old, for one of the greatest needs of the geriatrics patient is reliving his experiences through recounting them to an appreciative audience. Perhaps, instead of assuming that what the old folks need is basketmaking, leatherwork and knitting, we should give a little thought to their need for communication. Nurses, as well as laymen, often ignore the fact that the older person requires more than good physical care. He is also entitled to a fair hearing.—H. A. Adams, R.N.

Clysis Stat.

[*Continued from page* 49]

removed with care; either collodion and cotton or a small dry sterile dressing may be applied.

Should the area become white, painful, and hard to the touch, the rate of flow of the fluid should be decreased. The tube leading to the injected area may be clamped off for a time. Although the area may be gently massaged to hasten absorption once the needles have been removed, massage while the needles are stil' in place is not recommended for damage to the tissues may result.

Hyaluronidase

Recently, hypodermoclysis administration has become more practicable through the use of hyaluronidase preparations such as Alidase (Searle) *N.N.R.*; Wydase (Wyeth) *N.N.R.*; Diffusin (Ortho). Hyaluronidase, sometimes called the "spreading factor," is an enzyme which acts upon hyaluronic acid, the tissue cement found in almost all animals. When this "spreading factor" is introduced into the tissues at the beginning of a clysis, it so greatly reduces the viscosity of the hyaluronic acid that fluid travels through the intercellular spaces at a speed comparable to that obtained when given intravenously. Swelling and pain are negligible.

Hyaluronidase is defined in terms of *viscosity units* or *turbidity reducing units* depending upon the manufacturer. These terms are not interchangeable because they measure different properties.[4] The enzyme is supplied in the dried form, and 500 viscosity units or 150 turbidity re-

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2. Smooth on a protective film of *greaseless* Noxzema as a powder base.

Evening—3. "Creamwash" again. See how make-up and dirt disappear.

4. Use Noxzema as your night cream to help skin look smoother, softer, lovelier. Pat a little extra over any blemishes* to help heal them. It's *greaseless*—no messy pillow!

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ducing units are dissolved in 1 cc. of isotonic saline solution or in distilled water if the dried preparation already contains the necessary salt. It may be injected in the site chosen for the clysis prior to the insertion of the clysis needles, or the clysis may be started and the hyaluronidase then injected into the clysis tubing just above the needles. The tubing is of course cleansed before inserting the needle.

Hyaluronidase should never be injected into or about an infected area, for in breaking down the barrier to the spread of various electrolytes and fluids, it also breaks down the barrier to the spread of infection. Although in the ordinary clysis, the rate of flow needs only to be adjusted to the rate of absorption, with frequent checking for signs of overdistention of tissue, when hyaluronidase is used care must be taken that the speed of injection does not exceed that of the intravenous infusion.

Although the use of the "spreading factor" has helped to solve some of the problems connected with the subcutaneous administration of parenteral fluid, there seems to be little indication that the intravenous route has lost any of its popularity. I.V. administration of fluid will be discussed in a subsequent article.

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[1]John P. West, Manelva Keller, Elizabeth Harmon, *Nursing Care of the Surgical Patient*. 5th Edition; New York: The MacMillan Co., 1950, p. 118.
[2]M. Esther McClain, *Scientific Principles in Nursing*. St. Louis: The C. V. Mosby Co., 1950, p. 310.
[3]Robert Elman, *Surgical Care*. New York: Appleton-Century-Crofts, Inc., 1951, p. 127.
[4]*Journal of the American Medical Association*, Dec. 15, 1951, p. 1571.

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The Chiropodist

[*Continued from page* 28]

to the peripheral vascular disease patient. In fact, many of the major hospitals throughout the U.S. have instituted chiropody services which serve their diabetic, peripheral vascular, and orthopedic clinics.

Dr. Elliot P. Joslin, medical director of the Baker Clinic, Deaconess Hospital in Boston and Dr. H. Gray of the Cedars of Lebanon Hospital in Los Angeles, both eminent authorities on diabetes, have used chiropody services in the regular foot care of the diabetic patient. Both have been enthusiastic about the results. Dr. Gray stated that the number of cases of gangrene and subsequent amputations have been greatly reduced as a result of this chiropodical care.

A recent paper by Dr. H. H. Arenson of Santa Monica, California, demonstrates dramatically the drop in the number of cases submitted to the diabetic wards since the institution of a chiropody service in the Los Angeles County Hospital. This ever increasing number of glowing reports about this value of chiropody to peripheral vascular patients of all types, diabetic as well as non-diabetic, can be easily explained by the simple fact that since the earliest signs and symptoms of peripheral vascular disease are seen most often in the lower extremities, the chiropodist, who examines more feet than any other doctor, is well trained to detect these early signs and institute prompt treatment in close cooperation with the family physician or peripheral vascular specialist. This early detection and professional cooperation is preserving life and limb for many an American today.

Chiropody provides for better foot health from infancy to old age. Podopediatrics, the term given to the study of the diseases of children's feet, is a regular and important course of study in all approved colleges of chiropody. Preventive care is stressed and early detection and proper treatment prevent many foot disorders in childhood and in adult life. The most common of these early foot troubles are pronated feet, knock-knees, and flat feet, as well as more severe deformities of the deli-

cate bone and joint structures of the feet. The most common skin diseases seen in children's feet are plantar warts, fungus infections, ingrown and inverted toenails. A recent survey conducted under the direction of the National Association of Chiropodists among school children revealed the startling fact that the vast majority had some type of foot disorder.

The conclusion drawn from this scientific survey is that periodic examination and advice by the chiropodist can prevent and correct many of these foot conditions and help assure better foot health in adult life.

In adults, infections and various injuries, faulty gait and posture, excessive hours on the feet, overweight and general debility help to produce many chronic foot ailments. Often, aches and pains in the back, knees, and thighs are the result of foot imbalance. In these cases, a thorough examination, often including x-rays of the foot both on and off weight bearing, may reveal the underlying fault so that proper treatment may be instituted. Indiscriminate self-treatment with ready-made arch supports and so-called corrective shoes is often inadequate, if not harmful.

The fact that style demands the wearing of high heels by women accounts for the high incidence of foot and posture trouble in the fair sex. The calf and thigh muscles contract under these circumstances and increase the discomfort and symptoms. The modern chiropodist is equipped to aid and advise these patients.

Among men, the incidence of heel pain is common, probably due to the fact that weight is borne to a greater degree on this part of the foot. Early detection and treatment are necessary to prevent damage and chronicity.

Many men and women are victims of arthritis in middle life. Osteoarthritis, the most common type, often affects the foot. In fact, the big toe joint is the second most common site, second only to the knees. Foot posture plays an important role in both sites. Foot imbalance and pronation will often cause pain in the knee and big toe joints. Here, again, modern chiropody care by use of local injections and balance therapy may often produce a dramatic improvement.

The geriatric patient benefits from chiropody because of the added problems presented at this time of life such as lowered vitality, impaired circulation and loss of the normal adipose tissue which provides padding for the feet. Regular chiropody care can make these patients more comfortable as well as preventing much of the morbidity so common in old age. It has often been said that modern science has added "years to our lives" and now science must add "life" to these added years. Modern chiropody can aid in making old age healthier, happier and more pain-free.

In industry the chiropody profession is especially interested in persuading management to look after the foot health of their workers. A special committee of the National Association of Chiropodists has been

created to promote industrial foot health. Recent surveys of E. I. DuPont de Nemours and Company employes disclosed the striking fact that 90 per cent were found to suffer from some type of foot trouble. DuPont has since instituted a foot health service with excellent results. Foot troubles cost industry many millions every year. One employe out of ten has foot troubles serious enough to cause absenteeism, and one in four gets "afternoon fatigue" from his feet, thus interfering with efficiency and safety in these plants. Periodic examinations would disclose 95 per cent of pending foot disorders and more than repay the industry for the time and money expended. According to the *Wall Street Journal* of May 24, 1949, about thirty important companies have taken note of this situation and employ a full-time chiropodist to check employes.

Many of the nation's leading hospitals and clinics have active chiropody services. Other hospitals are constantly being added. Marcus Kogel, M.D., Commissioner of Hospitals, City of New York, in a recent address before the Podiatry (Chiropody) Society of the State of New York, stated, "You have earned the right to the Doctorate title—Doctor of Podiatry or Doctor of Surgical Chiropody . . . You have maintained and are maintaining important positions on the staffs of hospitals; some forty hospitals in New York State and about 1,000 throughout the country—and contributing to the continuous progress of the professions through teaching, practice, and research in the chiropody clinics affiliated with each of the accredited schools of chiropody . . . in the outpatient clinics, particularly in diabetic clinics. I know that Medical Boards appreciate and are grateful for this service. I would like to see an expansion of your activities in our hospitals."

Chiropody seeks the cooperation of medicine and the nursing profession in promoting the foot health of the American people. Thousands of Jane Stevens in the nursing profession can be helped by the modern chiropodist who fills a definite gap in medical care and is well fitted to assume the responsibilities of caring for the nation's feet.

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R.N. Speaks:

[*Continued from page* 25]

sorely needed by her patients and the profession. Yet the general attitude toward the older nurse is as old fashioned as using a washboiler for a sterilizer. If we don't soon plan for their use, those skills and qualities, if used at all, are doomed to be wasted. We have much to learn, whether it is in approaching the handicaps of old age or other kinds of physical incapacities in nursing. When General Motors can say, "We don't hire handicapped people, we hire skills," and mean it, it is time we look outside ourselves for enlightenment and guidance.

The American Nurses Association has at last appointed a committee to study the employment problems of the older nurse. We sincerely hope that the prevailing attitude of trying to find a job for the older nurse who can't keep pace physically with the youngsters in the profession will change to a more intelligent approach of classifying the jobs that are to be done, and then placing the older nurse according to her skills and ability to handle the job.

The whole cause of the nursing shortage is not in the publicized low salaries alone, nor in the lengthy period of preparation for the field. For career women with foresight, the job security in later years is as important as the opportunities of youth. In this area, the social work field can offer us real competition as can others.

—ALICE R. CLARKE, R.N., EDITOR

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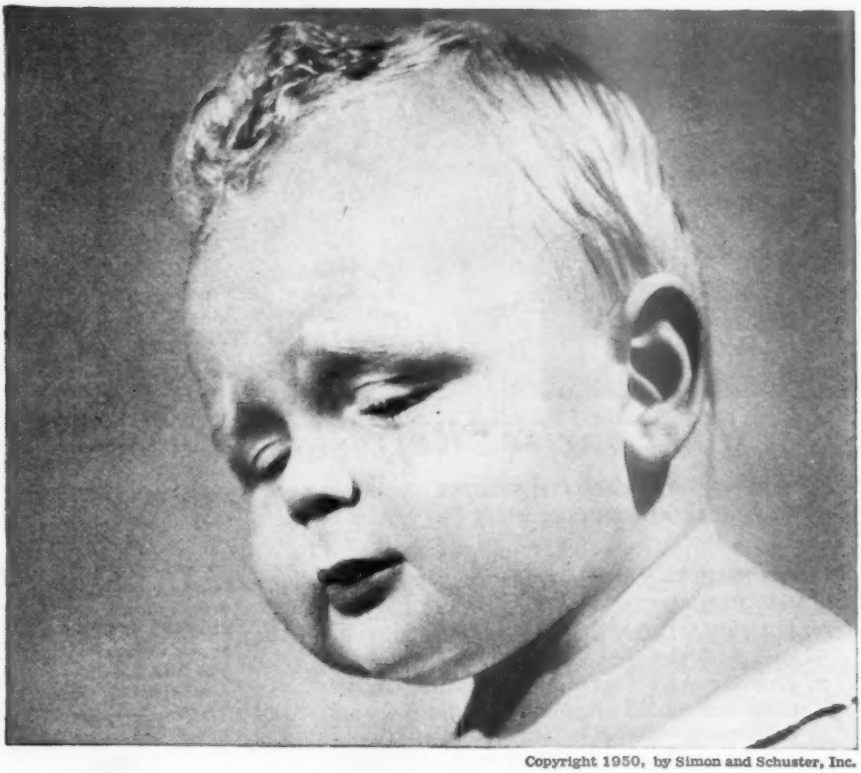

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ANESTHETIST, NURSE: 100 bed approved pediatric hospital. Light schedules, liberal personnel policies. Maintenance optional. Centrally located metropolitan area. Apply giving full particulars and when available. Salary open. Mr. D. O'Neill, Director, Babies' Hospital, 15 Roseville Ave., Newark, N.J.

ANESTHETISTS: (a) Well qualified, large active clinic, midwest university town. $6000. (b) California clinic-hospital, beautiful Sacramento Valley location. $4800-$6000. Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

ANESTHETISTS (NURSE): Two vacancies. A.A.N.A. Member. 626 bed general hospital. 10 nurse anesthetists on staff. Good salary and hours, liberal personnel policy. Apply Chief Anesthetist, Good Samaritan Hospital, Cincinnati 20, Ohio

ASST. DIRECTOR NURSING: (a) 200 bed college affiliated hospital, midwest city 75,000. $4000 up. (b) Southern college of nursing interesting varied duties. $5000. Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

ASSISTANT EDUCATIONAL DIRECTOR AND INSTRUCTING NURSES: Needed for expansion of accredited School of Practical Nursing. Two classes admitted annually; affiliation program in special services. Large modern general hospital with acute, chronic and tuberculosis divisions. Attractive residence and excellent personnel policies. Apply to Box BCH-2, R.N., The Nightingale Press, Inc., Rutherford, N.J.

ASSOCIATE DIRECTOR OF NURSES: For modern 2000 bed general hospital associated with outstanding medical school for teaching purposes. Expanding facilities provide opportunity for real achievement. Excellent personnel practices. Salary range $4200-$4900 with full maintenance. Address inquiries to Box BCH-1, R.N., The Nightingale Press, Inc., Rutherford, N.J.

CLINICAL INSTRUCTOR: For medical and surgical nursing in a fully accredited school of nursing. B.S. in Nursing Education is required. Good personnel policies, salary open. Write Nurse Administrator, Northwest Texas Hospital, Amarillo, Tex.

CLINICAL SCIENCE INSTRUCTOR: With a B.S. Degree for Nursing Training School of 50 students. Salary open. Apply Director of Nursing, The Orangeburg Regional Hospital, Orangeburg, S.C.

DIRECTOR OF NURSES: (a) Large, modern California hospital, well qualified nursing faculty. $6000 up. (b) Modern 200 bed hospital, north central resort region. $6000. Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

DIRECTOR OF NURSES: Hospital expanding to 150 beds, cooperative administration, attractive furnished apartment, location in progressive small city, salary open depending on qualifications. Write Audrain Hospital, Mexico, Mo.

DIRECTOR OF NURSING: 200 bed general hospital located in a community of 29,000 population. One hr. drive from seacoast resort. Hospital fully accredited and staffed with Director of Nursing Service and Educational Director of School of 80 students. B.A. or B.S. Degree required, M.A. Degree preferred. Salary open depending upon educational qualifications and experience. Apply Administrator, The McLeod Infirmary, Florence, S.C.

DIRECTOR OR NURSING SERVICE: For 650 bed Pennsylvania Tuberculosis Hospital. Liberal vacation and sick leave. 13 holidays with pay. Retirement plan. Beautiful location. Modern new apartment available. Nurses now on 44 hr. week with plans for

40 hr. week. Salary $3996-$4836 less maintenance. Apply Box CP-1 c/o R.N., Rutherford, N.J.

EDUCATIONAL DIRECTOR: Degree required, experience preferred. Accredited School of Nursing connected with 300 bed, well-equipped general hospital. One class annually. Sciences taught at nearby college. Salary open (all cash). Room available if desired. Liberal personnel policies. Hospital located near New York, Philadelphia and the Atlantic Coast. Apply Director of Nursing, Mercer Hospital, Trenton, N.J.

FACULTY APPOINTMENTS: (a) Educational Director, 150 bed modern hospital, north central college town. $4800. (b) Nursing Arts Instructor. Midwest college of nursing. $6000, opportunity for advancement. Woodward Medical Bureau, 185 North Wabash, Chicago, Ill.

GENERAL DUTY GRADUATE NURSES: Salary in keeping with those throughout Colorado. 80 bed general hospital, approved. Delightful climate, close to mountain resor' Apply Administrator, Mt. San Rafael Hospital, Trinidad, Colo.

GENERAL DUTY NURSE: 40 bed new general hospital, college town, resort area. Salary starts at $200 plus meals and laundry of uniforms. Retirement plan. Choice of rotating shifts or 11 to 7. Two weeks vacation with pay, sick leave, 6 holidays per year. R. Houfek, Ripon Municipal Hospital, Ripon, Wis.

GENERAL DUTY NURSES: Medical & Surgical Floors and Operating Rooms. Starting salary $240 per month ($11 day), 40 hr. week. Bonus for P.M. duty. Alternating shifts when necessary. Living quarters $18 per month, uniform laundry furnished. Excellent transportation to all areas. Doctors Hospital, 12345 Cedar Road, Cleveland Heights 6, Ohio

GENERAL DUTY NURSES: For nursing team in Medical and Surgical services. Opportunity for promotion and for University courses. Apply to Director of Nursing Service, University of Virginia Hospital, Charlottesville, Va.

GENERAL DUTY NURSES: Evening shift $210, night shift $220. 40 hr., 5 day week. 54 bed general hospital, Montclair Community Hospital, Montclair, N.J.

GENERAL DUTY NURSES: For 120 bed hospital. Starting salary $205 plus full maintenance. Surgical Nurses: Starting salary $215, additional $10 per month for evening and night duty. Regular increases. Nurses' home recently redecorated and refurnished. Liberal personnel policies. Hospital approved A.C.S. Southern Wyoming community of 12,000. Write or wire Director of Nurses, Memorial Hospital of Sweetwater County, Rock Springs, Wyo.

GENERAL DUTY NURSES: For 114 bed general hospital. Beginning gross salary $242 plus meals and uniform allowance. $10 evening and night bonus. 3-11 and 11-7 positions available. Apply Paul O. Huth, M.D., Supt., St. Francis Hospital, Cambridge, Ohio

GENERAL STAFF NURSES: Liberal personnel policies. 123 bed newly built and equipped hospital. For further information write Director Nursing Service, Magic Valley Memorial Hospital, Twin Falls, Ida.

GENERAL STAFF NURSES: 250 bed general hospital and 72 bed maternity hospital. Starting salary $240, $5 per month tenure increase for each 6 months of service to a maximum of $270. Two meals daily, Social Security, sick leave, prepaid medical and hospital care, $10 additional for afternoon and night duty, $15 additional for delivery room, $20 additional for surgery, up to 3 weeks vacation at end of 5 years, 7 paid holidays, 8 hour day, 40 hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, Calif.

GENERAL STAFF NURSES: 144 bed hospital located in Southern Colorado near mountain resorts, 44 hour duty, liberal personnel policies including Social Security. For information write Director of Nurses, Parkview Episcopal Hospital, Pueblo, Colo.

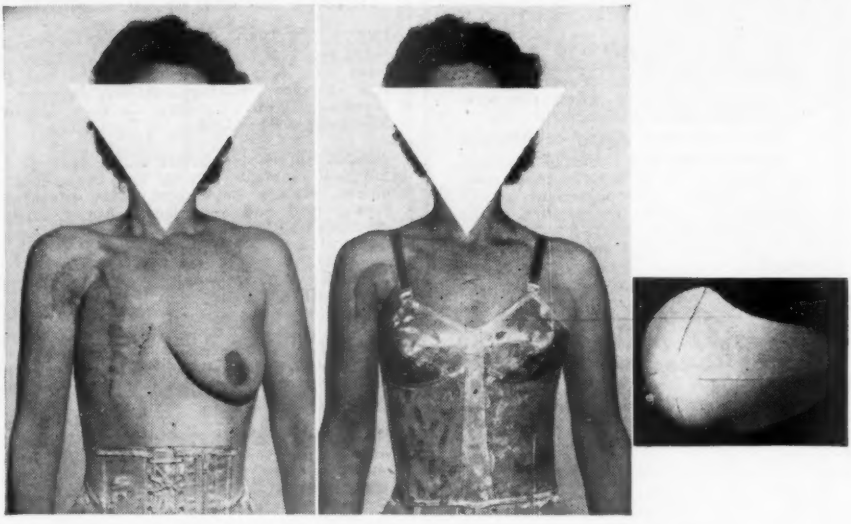
GRADUATE NURSES: For positions as evening and night supervisors; evening and night obstetrical supervisor; convalescent home supervisor; head nurses; general staff nursing all services. 200 bed general hospital. 9 paid holidays, liberal vacation and sick leave, step increases at 6, 12 and 18 months. $15 monthly differential 3 to 11, $10 11 to 7. Pleasant working conditions, good personnel policies. Apply Director of Nurses, Truesdale Hospital, P.O. Box 1511, Fall River, Mass.

GRADUATE NURSES: Unique opportunity in all clinical fields including tuberculosis. Large general hospital in East Coast City. Good starting salary, 5 day week, vacation and sick leave after 6 months. Modern nurses residence for those who wish to live in. Where outside living is preferred, room allowance is made. For information write Box BCH-5, R.N., The Nightingale Press, Inc., Rutherford, N.J.

GRADUATE NURSES: The University of Michigan Medical School offers to graduates of accredited schools of nursing a course in Anesthesia of one year duration, covering the administration of nitrous oxide, cyclopropane, ether, barbiturates and rectal agents. All modern techniques are taught including intratrachael, intravenous and the management of such specialties as thoracic and neuro-surgery. For information, write the Department of Anesthesiology, University Hospital, Ann Arbor, Mich.

INSTRUCTOR: For medical and surgical nursing. B.S. in Nursing Education and/or equivalent experience. 280 bed hospital. School of 115 students, salary open. Apply Director of Nursing, Norton Memorial Infirmary, Louisville, Ky.

INSTRUCTOR & ASST. INSTRUCTORS IN NURSING ARTS: Positions open for fall term in a general hospital of 325 beds. 40



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hr. week. Apply Director, School of Nursing, The Toledo Hospital, Toledo, Ohio

INSTRUCTORS: Medical and Surgical Nursing. 225 bed hospital, 75 students. At least one year of teaching experience and B.S. Degree required. Apply Director of Nursing, Santa Barbara Cottage Hospital, Santa Barbara, Calif.

INSTRUCTORS—CLINICAL: Medical & Surgical Nursing. Degree and experience required. Salary dependent upon educational background and experience. Apply Director of Nursing, The Toledo Hospital, Toledo 6, Ohio

NURSE: An interesting position for the right person (assistant to owner) who would be capable of assuming responsibility in a well established, small and ideal Nursing Home. R.N. not necessary but nursing essential. Salary open. Located in New Jersey. Answer giving credentials to Box 558, Morristown, N.J.

NURSE ANESTHETIST: 250 bed hospital, well equipped and fully approved, predominately surgery. Top salary, meals and laundry furnished, good hours, sick leave, vacation and holidays. Apply Administrator, Mid State Baptist Hospital, Nashville, Tenn.

NURSE ANESTHETISTS: (Member of A.A.N.A.)to complete staff of 10 for 1000 bed hospital. 40 hr. week with straight pay for overtime. Annual vacation, accumulative sick time and retirement benefits. Quarters available. Dept. of Anesthesiology, University Hospital, Ann Arbor, Mich.

NURSES: Moving to new hospital and new apartment-style nurses' residence in summer of 1952. 236 bed general hospital 30 miles from New York City. Wanted immediately: Supervisors, Head Nurses, Assistant Head Nurses, General Duty Nurses. Liberal personnel policies. Write Director of Nursing, Morristown Memorial Hospital, Morristown, N.J.

NURSES: General duty, ($3753-$4087), Head ($4236-$4670) and Supervisory ($4733-$5260) for general emergency nursing in large city hospital affiliated with university medical school and acute communicable and TB nursing positions in two large tuberculosis hospitals using most progressive methods. 40 hr. week, no split-shifts, paid vacations, sick leave, duty disability allowances, pensions, maternity leaves, educational leaves, in-service training, excellent opportunities for further schooling. Apply Detroit Civil Service Commission, 735 Randolph St., Detroit 26, Mich.

NURSES: Operating Room and General Duty. 42 bed, new well-equipped hospital. 40 hr. week, top salary. Apply Administrator, Tracy Hospital, Tracy, Calif.

NURSES: Graduate registered nurses for Operating Room. Graduate registered nurses for evening and night duty. Good salaries, 40 hr. week. 10% differential of basic salary for evening and night duty. Head nurse for new unit to be opened about July 1, 1952.

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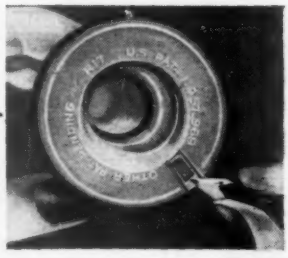

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Apply Director of Nurses, Woman's Medical College Hospital of Pa., Henry Ave. and Abbottsford Rd., Philadelphia, Pa.

NURSES: For modern 650 bed tuberculosis hospital affiliated with Western Reserve University. 40 hr. 5 day week. Salary $272 to $300, with automatic increases. Full maintenance available at minimum rate. Usual holidays, vacation and sick time allowance. Advancement for desirable applicants. Apply to Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio

NURSES: Supervisors, combined X-Ray and Lab Technician. Salary pending. General duty nurses, $185 per month with complete maintenance. Vacation with pay. Write giving qualifications and experience to Myrtice P. Sheffield, Superintendent, Suwannee County Hospital, Live Oak, Fla.

NURSES: For outstanding Medical Center in the Southwest, Atomic Energy Plant. $255 mo., 40 hr. week, 3 weeks vacation. U.S. Citizens only. Write full particulars, Personnel Manager, Los Alamos Medical Center, Los Alamos, N.M.

NURSING ARTS INSTRUCTOR: Immediate opening. Affiliated with Junior College for Pre-Clinical Sciences. One class admitted yearly. 190 bed general non-sectarian hospital. Summer resort area in the heart of the fruit belt. 90 miles from Chicago. Liberal personnel policies. Salary commensurate with preparation and experience. Mercy Hospital, Benton Harbor, Mich.

NURSING ARTS INSTRUCTOR: 280 bed hospital, school of 115 students, one class a year. Degree or working toward a degree and experience necessary. Salary open. Apply Director of Nursing, Norton Memorial Infirmary, Louisville, Ky.

NURSING ARTS INSTRUCTOR: Degree in Nursing Education required. Experience desirable. Salary open. Apply Director of Nursing, Franklin Hospital, San Francisco 14, Calif.

OBSTETRIC SUPERVISOR AND ADMINISTRATIVE SUPERVISOR OF CHRONIC DIVISION: These are interesting positions in large modern general hospital in the East. 5 day week and liberal vacation. Excellent maintenance in addition to salary. $3500 to $4100. Write Box BCH-4, R.N., The Nightingale Press, Inc., Rutherford, N.J.

OFFICE NURSE: Single, under 35 years. Permanent. Good wages. S. L. Hardy, M.D., Las Vegas Hospital, Las Vegas, Nev.

OPERATING ROOM NURSES: 250 bed general hospital. Eligible for registration in Colo. Excellent personnel policies. Beginning salary $227.50 with regular merit increases. Maintenance available. Apply Director, Nursing Service, St. Anthony Hospital, Denver, Colo.

OPERATING ROOM SUPERVISOR: $4733-$5260 per yr. for large general city hospital affiliated with university medical school. 40

(An educational advertisement of interest to all women)

THERE'S A *New Freedom* FOR WOMEN

by OLIVE CRENNING, *Nursing Consultant*

Doctor-invented method offers greater comfort and assurance during menstruation.

Until a few years ago, it was necessary for a woman to be hampered by uncomfortable, bulky sanitary protection. Her activities such as swimming and bathing had to be limited during several days of the month. Then a doctor invented a modern, internal form of sanitary protection known as tampons. Now, tampons offer women greater comfort and peace of mind during those trying days.

A recent national survey of 900 leading gynecologists and obstetricians indicates that medical specialists overwhelmingly find tampons safe for normal women. Tampons are regularly used by thousands of registered nurses.

Tampons completely eliminate the need for sanitary belts, because they are worn internally. There is no possibility of odor which forms only on contact with air. Bothersome chafing and uncomfortable bulk are eliminated. The woman who uses tampons can take part in active sport . . . swim, bathe, and shower in perfect safety (provided the water is not too cold).

For the young, unmarried girl, tampons offer the same reassuring, safe protection. Medical literature shows that no change in physical structure is involved when a single girl wears tampons. College girls, with a knowledge of anatomy and biology, form one of the largest groups of tampon users. They find that the comfort and freedom from embarrassment materially eases the problems of menstruation.

Better tampons, like Meds, are made of soft, amazingly absorbent surgical cotton. They are quicker and easier to use because each has its own specially designed applicator. There is no other tampon like Meds. To meet individual needs, Meds come in Junior, Regular and Super absorbency sizes.

You, too, will be enthusiastic about the comfort and convenience of Meds tampons. For a free sample of Meds in plain wrapper, write Miss Olive Crenning, nursing consultant, Personal Products Corp., Dept. RN-7, Milltown, N. J. (One package to a family, U. S. only.)

hr. week, liberal paid vacations, sick leave, pension system, duty disability allowances, Civil Service Status, educational leaves. Apply Detroit Civil Service Commission, 735 Randolph St., Detroit 26, Mich.

PSYCHIATRIC NURSES: For a psychoanalytically oriented 70 bed hospital, active treatment program. Psychiatric experience preferred. Eligibility for Kansas registration required. In-service program designed to improve nursing care, 44 hr. week (alternating 40 and 48 hrs.), rotating shifts, 15 days sick leave per year, accumulative to 60 days, 3 weeks vacation. Starting salary $250, annual merit increases to $325 for staff positions, $15 differential for night and evening duty, laundry of uniforms provided. Eligible for retirement plan after 3 years. For further information address Mr. Basil Cole, Personnel Director, The Menninger Foundation, Topeka, Kans.

PSYCHIATRIC NURSES: R.N. for supervisor of nurses, also R.N. for night duty head nurse. 60 bed private progressive psychiatric hospital. Complete maintenance furnished. Salary open. 10 miles from Baltimore. Apply Medical Director, Pinel Clinic, Ellicott City, Md.

PUBLIC HEALTH: Supervisor, small agency, Visiting Nurse Service. Good personnel policies. 5 day, 40 hr. week. Allowance for car. Salary open depending on experience and preparation. Public Health Nursing Association of Bloomfield & Glen Ridge, 392 Franklin St., Bloomfield, N.J. BL 2-0138.

PUBLIC HEALTH: Staff Nurse, experienced, small agency, Visiting Nurse Service. Good personnel policies. 5 day, 40 hr. week. Salary $2520-$3000. Allowances for car. Public Health Nursing Association of Bloomfield and Glen Ridge, 392 Franklin St., Bloomfield, N.J. BL 2-0138.

PUBLIC HEALTH NURSE: 83 bed hospital, large clinic. Starting salary $241-$273 month, 40 hr. week. U.S. Citizen only. Apply Personnel, Los Alamos Medical Center, Los Alamos, N.M.

PUBLIC HEALTH NURSES: Vacancies in New York City Department of Health. Immediate appointment on provisional basis. Generalized service includes maternal and child care, school health and communicable disease control. Starting salary $2650. 37 hr. week, liberal vacation and sick time allowances, pension rights, in-service training. Applicants (except New York State Veterans) must not have reached 36th birthday. Write to Bureau of Public Health Nursing, City Health Department, 125 Worth St., New York 13, N.Y.

PUBLIC HEALTH TRAINING PROGRAM. Open to graduate nurses, 20 to 30 years, $3560 to $3833 per yr. Trainees take academic work at University while gaining paid experience in field. Other openings for trained public health nurses, 22 to 35 years, $3835-$4213 per year. 40 hr. week, liberal paid vacations, sick leave, pension system, Civil Service status, educational leaves. Apply Detroit Civil Service Commission, 735 Randolph St., Detroit 26, Mich.

REGISTERED NIGHT NURSE: $225 plus complete maintenance. Must know obstetrics. Imperial Community Hospital, L. A. Garber, R.N., Supt. Imperial, Neb.

REGISTERED NURSE: For 40 bed hospital. 44 hr. week, liberal personnel policies, starting salary $225 with full maintenance. Write Administrator, Sanford Hospital and Clinic, Perryton, Tex.

REGISTERED NURSE: Operating room. Small hospital. $300 per month, plus room, board and uniform laundry. 6 days week. White Pine General Hospital, Ely, Nev.

SCIENCE INSTRUCTOR: No chemistry. 40 hrs. Monday through Friday. Good salary, maintenance and personnel policies. Position must be filled by August 15th. Apply Isabel M. Hutchison, Director The Memorial Hospital, Danville, Va.

STAFF NURSES: All shifts, any division. Salary $250 per month, 48 hr. week. Generous personnel policies. New 102 bed hospital and nurses' home. Excellent opportunities for advancement. Apply Director of Nurses, Midland Memorial Hospital, Midland, Tex.

DAIRY FOODS – essential to our nation's strength

For better work and better health

Research emphasizes the importance of a good breakfast, yet many workers start the day with little or no food.

Omitting breakfast has been found to decrease maximum work output.[1] Breakfast, containing milk as a source of animal protein, reduces midmorning fatigue, and gives a feeling of well-being. The rate of decline of blood sugar levels is slowed after breakfasts with liberal amounts of protein . . . delaying onset of hunger and tiredness.[2]

Adding a glass of milk to a breakfast of fruit, bread, and butter was shown, in a recent study, to increase efficiency of protein utilization. Redistributing animal protein by shifting milk to breakfast was effective, though the day's total protein supply was unchanged.[3]

An adequate diet, including dairy foods and other protective foods, can be a great asset in increasing efficiency of workers and building national strength.

1. Tuttle, W. W., Daum, K., Myers, L., and Martin, C. Effect of omitting breakfast on the physiologic response of men. J. Am. Diet Assn. *26*:332 (May) 1950.

2. Orent-Keiles, E. and Hallman, L. F. The breakfast meal in relation to blood sugar values. U.S.D.A. Cir. 827. Washington, 1949

3. Leverton, R. M. and Gram, M. R. Nitrogen excretion of women related to the distribution of animal protein in daily meals. J. Nutr. *39*:57 (Sept.) 1949

STAFF NURSES: In hospital for children with rheumatic fever. Excellent salary, good working conditions, maintenance, vacation. Near New York City. Apply Medical Director, Irvington House, Irvington, N.Y.

SUPERVISOR: 56 bed nursing home. Must be a R.N. with at least one year experience in supervision. At present time a R.N. is employed for night supervision. 22 practical nurses employed. Responsibility for the total nursing care. Salary $200 month, complete maintenance. Mrs. Jessie Jolliffe, R.F.D. 2, Silver Spring, Md.

SUPERVISOR: Of subsidiary workers in Nursing Service. Asst. Supervisor of Obstetrics with emphasis on teaching obstetrics to nursing students. Middlesex General Hospital, New Brunswick, N.J.

SUPERVISOR: Public Health Nursing Supervisor for visiting nurse organization with 6 staff nurses and student program covering an area with approximately 60,000 population. Preparation and experience which meet NOPHN standards required. Salary open. One month vacation, 2 weeks sick leave, retirement plan, mileage allowance. Write to Director, Elmira Visiting Nurse and Tuberculosis Association, Elmira, N.Y.

SUPERVISORS: Obstetrics, operating room, medical and surgical (3-11); also staff nurses. 48 hr. week, 60 bed new hospital, city of 20,000, home of two large state colleges, 35 miles from Dallas and Fort Worth. Starting salaries, $215 to $245 depending on education and experience. Meals provided while on duty. Apply Supervisor of Nurses, Flow Memorial Hospital, Denton, Tex.

(a) ADMINISTRATORS: (1) To succeed 3rd supt. vol. gen'l hosp. estab'd '19, 125 beds, small town near univ. city. E. (a) New hosp. 60 beds, resort town, MW. (b) **ANESTHETISTS:** (3) Hosp. & Clinic of outstanding specialists. $500. Pacific Coast. (4) Ass'n with anes. group, coll. town, MW. (5) New hosp., gen'l, 300 beds, univ. city, SW. $500. (6) Ass'n with oral surgeon, Calif. (c) **COLLEGE, INDUSTRIAL, OFFICE:** (7) College. Young women's coll., res. town near NYC. (8) Indus. 800 employees. Coll. town, MW. (9) Office. Qual. take complete charge office, busy internist, Diplomate, Chicago area. (10) Indus. New plant, univ. town, So. (11) College. Take charge infirmary, liberal arts coll. suburb lge. city, med. center. (12) Clinic. 5 specialists. Resort town, SW. (d) **DIRECTORS OF NURSES:** (13) Gen'l hosp. 225 beds expanding to 300. 70 students, well staffed, attrac. location, Calif. Min. $6000. (14) Important hosp. fairly lge. gen'l, affil. med school, New England. (15) Large teaching hosp. univ. center, So. $7200. (16) Nursing service only, 200 bed gen'l hosp. coll. town, MW. $6000, mtce. (e) **FACULTY APPOINTMENTS:** (17) Educational Director, collegiate school, Calif. $5000, mtce. (18) Nurs. Arts Instruct. Duties, teaching at liberal arts college, school, 300 bed gen'l hosp. univ. town. Min. $500. (19) Science. Vol. gen'l hosp. 500 beds, near univ., oppor. graduate study, famed school, 250 students, E. (20) Clinical instructors in medicine, ob-

"...On the feet of Individuals."

Society advances on the feet of individuals. We Americans live under the highest standard ever achieved because we believe in and are permitted currently to practice three of the cardinal principles of progress—Invention, Research and COMPETITION.

Nineteen basic inventions influence our pattern of life today. Each one was created to satisfy a fundamental need. For example, the electric light industry has grown to an annual volume of $501,500,000 in light bulbs alone; the value of aviation manufactures in 1951 in the United States alone was estimated at $3,350,000,000 and in February, 1952, records show a $10½ billion backlog of orders.

In every case, employment and sales volume grew enormously and the public enjoyed huge personal benefits.

Side by side with Invention came Research, exemplified by the competition of intelligent men questing for new materials, new methods, new processes, new scientific truths. Current advertisements tell of hundred-year tests to assure better materials for the future, technology that produces metals to withstand almost inconceivable heat, machines calculating 20,000 times faster than the mind of man, medicines that cure "incurable" diseases, food processes that cook, sterilize and pack hundreds of cans a minute. And in every case, the public enjoys huge personal benefits.

This is what James A. Decker undoubtedly had in mind when he wrote the line, "Society advances on the feet of individuals." These "individuals" are you and I, all our countrymen, benefiting every day from Invention, Research—and COMPETITION.

Developing inventions, marketing products, and pursuing scientific research require substantial investments. A grave danger to their future now looms. In 1951, corporation net profits suffered a loss of 21% over the previous year. The reason—taxes too high, government controls and policies that interfere too greatly with private industry. If this continues, financial resources will dwindle, competition will be stifled.

Without free competition, American progress stops. No country can long exist when its government calls all the shots. We need competition to assure progress for people.

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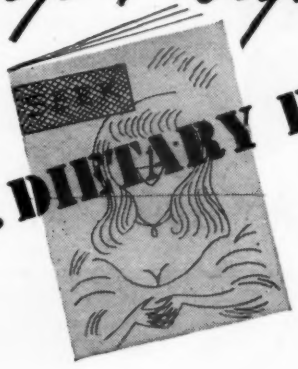
gyne., surgery, pediatrics. Univ. school, apartments available beautiful new apt. bldg., liberal personnel policies, substantial salaries, lge. city, medical center, MW. (f) **GENERAL DUTY:** (21) Industrial hosp., small town, SW. $365, mtce. (22) Modern, well-equipped hosp., foreign operations, Amer. company, $325 plus living allowance, $230. (23) Two, new hosp., coast town, Alaska. $300, mtce. (24) Five, general hosp., So. Pac. $4200, mtce. (g) **MALE NURSES:** (25) Institutional apptmt, psy. training desirable. Min. $330, MW. (26) Anes., small gen'l hosp., Wis. Min. $500, up. (27) Ass't dir. of nurses, 400 bed gen'l hosp., MW. (h) **SUPERVISORS:** (28) Clinic, pref. trained public health, and night. 600 bed teaching hosp., oppor. continuing studies, MW. (29) Chief O.R. and departmental supervisors, new hosp., 300 beds, affil. 25 man group, coll. town, E. (30) Outpatient. Teaching hosp, univ. town. Min. $325, lge. city, medical center. (31) Floor. New hosp., small size, fashionable suburb, college town near Chicago. (32) OB. New hosp., 300, unit univ. group, SW. (33) Ped., univ. hosp., apartment provided, beautiful new residence. Lge. city, leading medical center. (34) Chief OR, 350 bed univ. hosp., service mainly surg., univ. center. $5000. (i) **SURGICAL NURSES:** (35) New Hosp. small size, coast town Calif. (36) Ass't surgeons, 26 man clinic, univ. center, MW. (37) gen'l hosp. under Amer. auspices, Latin America. (Please send for our Analysis Form so we may prepare an individual survey for you. Medical Bureau, Burneice Larson, Director, Palmolive, Chicago, Ill.)

Top Flight Model

...DIETARY DUB



SHE's a model of perfection—in everything except her diet. Often too busy to eat, she relies on snacks and coffee to keep going from morning until night. At this pace, she'll soon be posing as a subclinical vitamin deficient.

To bring her back to vitamin balance, she may need a corrected diet—*plus* an effective vitamin supplement such as SUR-BEX WITH VITAMIN C.

In addition to providing six important B vitamins (including B_{12}), each SUR-BEX WITH VITAMIN C tablet supplies 150 mg. ascorbic acid—five times the minimum daily requirement. One easy-to-swallow tablet is the prophylactic dose. Two or more for severe deficiencies. In bottles of 100, 500 and 1000. **Abbott**

Each SUR-BEX WITH VITAMIN C tablet contains:

Thiamine Mononitrate	6 mg.
Riboflavin	6 mg.
Nicotinamide	30 mg.
Pyridoxine Hydrochloride	1 mg.
➡ Vitamin B_{12} (as vitamin B_{12} concentrate)	2 mcg.
Pantothenic Acid (as calcium pantothenate)	10 mg.
➡ Ascorbic Acid	150 mg.
Liver Fraction 2, N.F.	0.3 Gm. (5 grs.)
Brewer's Yeast, Dried	0.15 Gm. (2½ grs.)

Sur-bex®

with VITAMIN C

(Abbott's Vitamin B Complex with Ascorbic Acid)

R.N. SUBJECT INDEX

JAN.-JUNE, 1952
VOL. 15, NO. 4-9

FASHION SOURCES

Jantzen's land-and-water swim suits 41
No. 2L-88, $10.95; 2L-90, $12.95
Leading department stores, or write
Jantzen Knitting Mills
Portland 14, Ore.

Strapless, sunback dress No. 8189 41
Cole of California
Fruitland Road
Los Angeles, Calif.
Attention: Mr. Fred Cole

Gilead's cotton bra-slip 42
United Mills Corp.
180 Madison Ave.
New York, N.Y.
Attention: Miss Marie Curie

Tommy pajama-suit and coat 42
Kaylon, Inc.
180 Madison Ave.
New York 16, N.Y.
Attention: Miss Stephanie Talbot

Cotton "Turnabout" 43
Franklin Simon, N.Y. or
Royal Robes, Inc.
16 E. 34th St.
New York, N.Y.

Cotton blouse trio 44
Ship 'n Shore
Susquehanna Waist Co.
1350 Broadway
New York, N.Y.

"Terry Susans" 44
Bruck's Shops
640 Madison Ave.
New York, N.Y.
Attention: Mr. Westermann

"Zurich" Wedgies 44
Jantzen Shoe Division
Portland 14, Ore.

"Butterfly Net" bags 44
Alan Handbags
30 E. 33rd St.
New York, N.Y.

Chalk-white beads 44
Coro, Inc.
47 W. 34th St.
New York, N.Y.
Attention: Miss Hester Brown

Uniform ..... Front cover
White Rock Uniform Co., Inc.
5 N. Village Ave.
Rockville Centre, N.Y.

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By stimulating the sale of the new and the resale of the old, our competitive system achieves widespread ownership of automobiles, as with almost everything else. In most foreign countries, out of necessity people make things last as long as possible. In the U. S. A., vigorous competition prompts continuous progress. Buyers of new cars get maximum value, because each manufacturer competes actively for the new-car dollar. Lowest-income groups benefit by the lowered prices of used, yet essentially useful, products. Overall result: The world's highest standard of living. In most of the rest of the world, only the rich enjoy luxuries. In the U. S. A., the irresistible drive of competition places most of the miraculous products of modern living within reach of all.

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You will have the chance to take post-graduate training in many nursing fields and to qualify for advancement.

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